

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01368

Reg. Dist. No. 38

## 1491 CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <b>Lutherville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>College Manor Nursing Ho.</b>				STREET ADDRESS (If rural give location) <b>Northway Apts.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>MAUDE WILSON ADAMS</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Feb. 14, 1956</b>			
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>widowed</b>	8. DATE OF BIRTH: <b>Nov. 21, 1871</b>	9. AGE last birthday <b>84</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>?</b>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>George Williams</b>				14. MOTHER'S MAIDEN NAME: <b>Harriette Hancock</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>Mrs. Alberta W. Lenzen-Northway Apts.</b>			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Arterio-sclerotic Heart Disease</b>						<b>5 yrs.</b>	
ANTECEDENT CAUSE (B) <b>Cerebral arterio-sclerosis</b>						<b>2 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0 None</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>JUNE, 1951</b> , to <b>Feb. 14, 1956</b> that I last saw the deceased alive on <b>Dec. 15, 1955</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Crawford N. Kirkpatrick Jr.</b>		M.D. <b>6 E. Eager St., Baltimore 2, Md.</b>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/17/56</b>		NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS <b>2401-4</b>	

Washington, D. C.

January 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

W. A. RORER, Secretary.

Very truly yours,

01361

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1402 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Glenarm P.O.</u>	<u>25 yrs</u>	TOWN <u>Glenarm P.O.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Long Green md</u>		<u>Long Green md</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Eleanora</u>	(Middle) <u>Albrecht</u>	(Last)	
(Type or Print)		DATE OF DEATH: <u>Feb 19 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>		<u>Jan 31-1872</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>84 yrs.</u>	Months	Days	Hours
			Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>At Home Housekeeper</u>		<u>Balto md</u>	<u>USA</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Philip A Albrecht</u>		<u>Eleanora Feyman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>NO</u>		<u>Mr Chas A Albrecht, Glenarm P.O.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		<u>10 MOS.</u>	
ANTECEDENT CAUSE (S)		<u>2 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Congestive Heart Failure</u>			
(B) <u>Arterio sclerotic Heart Dis.</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg. etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/24</u> , 19 <u>55</u> to <u>2/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>56</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Clifford F. Hudson M.D.</u>		<u>Feb. 20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/22/56</u>	<u>Baltimore Cen</u>	<u>Balto md</u>
DATE RECD BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/22/56</u>	<u>Mrs. Hammett</u>	<u>Larsahn Funeral Home</u>	<u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

VS. A15-10153

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Clifford Hudson

FOUR 2d



BUREAU V. S.

MAR 7 1956

RECEIVED



01362

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1403 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Baltimore</u>		<u>24</u> days		TOWN <u>Baltimore</u> <u>3701-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1800 Etting Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>WILLIAM B. ALLEN</u>				<u>February 4, 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>12/11/01</u>	
				9. AGE last birthday: <u>54</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Trucking Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Millwood, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Allen</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Bray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>215-12-8855</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		RECENT	
(A) <u>HEPATIC COMA</u>			
DUE TO			
(B) <u>LAENNEC'S CIRRHOSIS</u>		UNKNOWN	
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

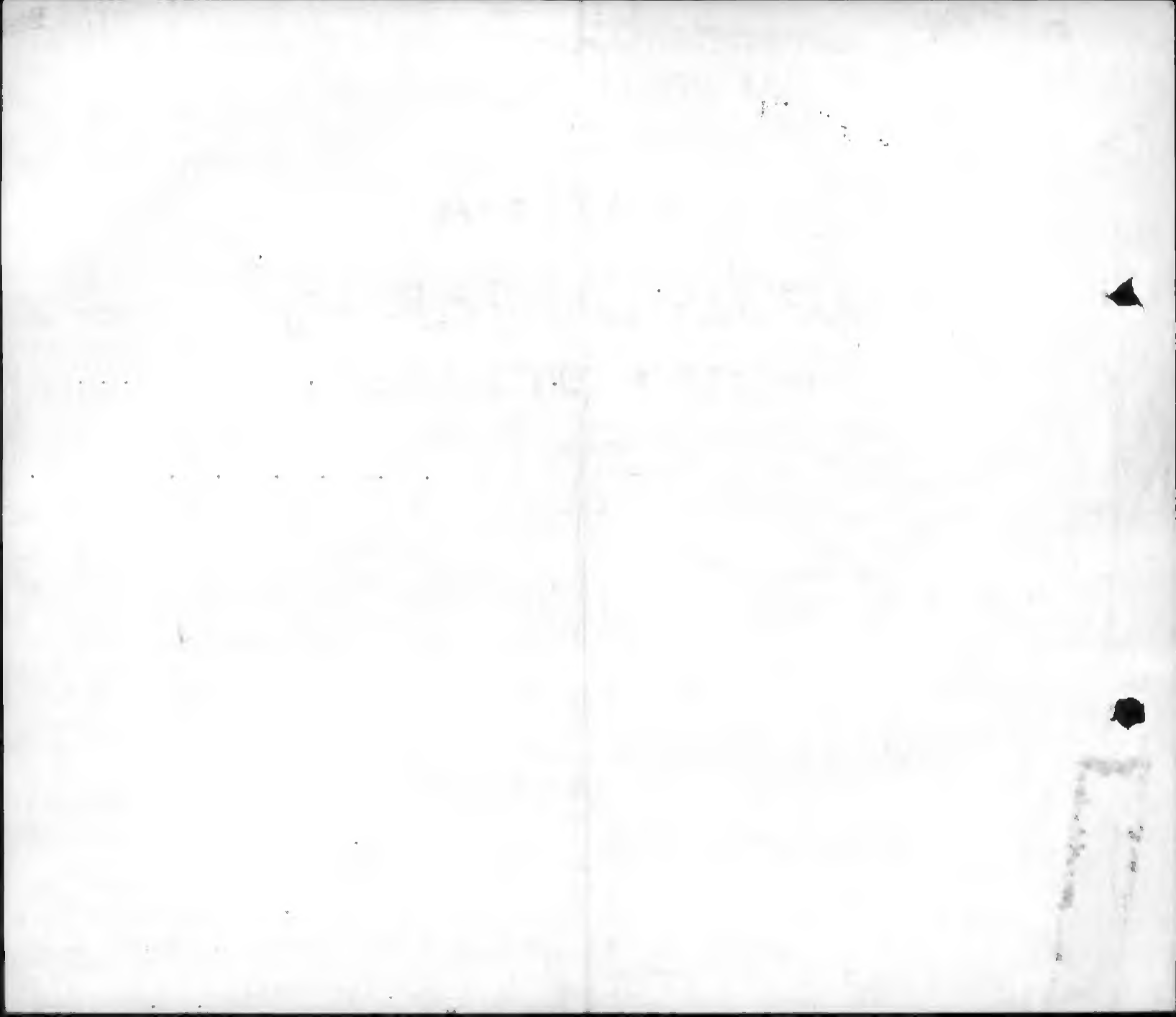
22. I hereby certify that I attended the deceased from Jan 12, 1956, to Feb. 4, 1956, that I last saw the deceased alive on XXXXXXXXXXXXXXX and that death occurred at 9:40 A.M., from the causes and on the date stated above.

SIGNATURE <u>John A. Sidmonte</u>		ADDRESS <u>M. D. Fort Howard, Md.</u>		DATE SIGNED <u>2/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
				LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 6, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Charles R. Law Funeral Home</u>	
				ADDRESS <u>802 Madison Ave., Baltimore 1, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-10-55



1494

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Owens</u>		<u>25 years</u>		TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Cliftwood Rd</u>				STREET ADDRESS (If rural give location) <u>11 Cliftwood Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>John Wesley Amoss</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 4 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>9-19-78</u>	
9. AGE last birthday <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hickster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown Amoss</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213302468</u>		17. INFORMANT & ADDRESS <u>Daughter, 11 Cliftwood Rd</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 31, 1956</u> , to <u>Feb. 4, 1956</u> , that I last saw the deceased alive on <u>Jan. 31, 1956</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ronald J. Anderson</u>				ADDRESS (Street, city, town, state) <u>M.D. 1077 Harford Rd. Baltimore 14, Md. 21244</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 8, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Louder Park</u>		LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 9 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. L. L. Reifensnyder</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home - 7401 Belair Rd.</u>		ADDRESS	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

013002

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

1908

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		SINGLE	
BIRTH DATE		BIRTH PLACE		BIRTH TIME	
BIRTH WEIGHT		BIRTH LENGTH		BIRTH HEAD	
BIRTH COLOR		BIRTH HAIR		BIRTH EYES	
BIRTH BUILD		BIRTH SKIN		BIRTH TEETH	
BIRTH FINGER		BIRTH TOES		BIRTH NAILS	
BIRTH CLOTHES		BIRTH ACCESSORIES		BIRTH OTHER	
BIRTH SIGNATURE		BIRTH ADDRESS		BIRTH CITY	
BIRTH STATE		BIRTH COUNTRY		BIRTH RESIDENCE	
BIRTH OCCUPATION		BIRTH EDUCATION		BIRTH RELIGION	
BIRTH MARITAL STATUS		BIRTH SINGLE		BIRTH MARRIED	
BIRTH WIDOWED		BIRTH DIVORCED		BIRTH OTHER	
BIRTH SIGNATURE		BIRTH ADDRESS		BIRTH CITY	
BIRTH STATE		BIRTH COUNTRY		BIRTH RESIDENCE	
BIRTH OCCUPATION		BIRTH EDUCATION		BIRTH RELIGION	
BIRTH MARITAL STATUS		BIRTH SINGLE		BIRTH MARRIED	
BIRTH WIDOWED		BIRTH DIVORCED		BIRTH OTHER	

BUREAU V. 2

RECEIVED

FEB 10 1908

RECEIVED  
BUREAU OF VITAL STATISTICS  
BALTIMORE, MD.  
FEB 10 1908

## 1405 CERTIFICATE OF DEATH

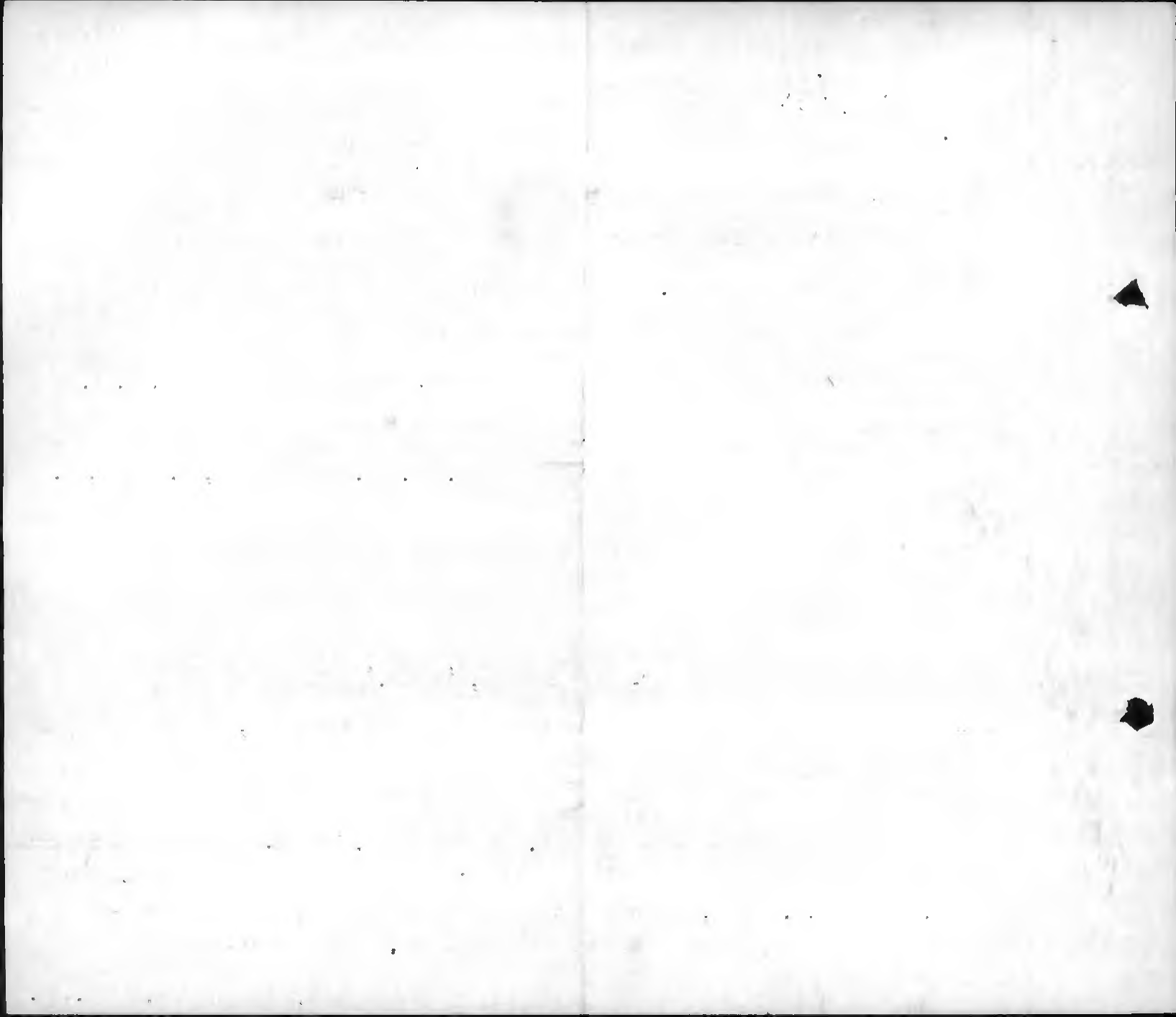
Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>3 Days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>206 NORTH CHAPEL STREET</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>LEMUEL T. ANDERTON</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>FEBRUARY 13 19 56</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>January 29, 1897</b>
9. AGE last birthday <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Waterman</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Sanford, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME: <b>Lee Anderton</b>		14. MOTHER'S MAIDEN NAME: <b>Caroline Andrews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT & ADDRESS: <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <b>ACUTE BRAIN SYNDROME OF UNKNOWN CAUSE</b>		UNKNOWN
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <b>(1) Tenosynovitis, acute, right second finger. (2) Bronchitis, chronic. (3) Bronchial asthma</b>		
19A. DATE OF OPERATION: <b>2-10-56</b>	19B. MAJOR FINDINGS OF OPERATION: <b>Incision and drainage of tenosynovitis and felon, right</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Feb. 10, 1956</b> , to <b>Feb. 13, 1956</b> , and that death occurred at <b>7:35 A.M.</b> , from the causes and on the date stated above.		
SIGNATURE <b>Joseph M. Miller</b>		DATE SIGNED <b>2-13-56</b>
ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Feb. 16/56</b>	NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>
LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Philip Herwig</b>	24. FUNERAL DIRECTOR ADDRESS <b>Philip Herwig Sons, 2024 Orleans, Balto., Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC T-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01365

1406

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Hereford</u>		LENGTH OF STAY (In this place) <u>50 yrs</u>		OR TOWN <u>Hereford</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>		STREET ADDRESS <u>York Rd.</u>					
3. NAME OF DECEASED (Type or Print) <u>Harry Scott Armacost</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>Febr 23</u> 19 <u>56</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 6/1888</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shute Operator Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Markton, Md. R.D.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joshua Armacost</u>				14. MOTHER'S MAIDEN NAME <u>Lida Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-28-1752</u>		17. INFORMANT & ADDRESS <u>Mrs. Grace Armacost Markton Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Arterio Sclerosis Cerebrovascular</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 22, 1956</u> to <u>Feb 23, 1956</u> , that I last saw the deceased alive on <u>Feb 22, 1956</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Porter</u> M.D. <u>White Hall Md.</u>				DATE SIGNED <u>Feb. 25, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Febr 26/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Fosters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hereford Markton, Md. R.D.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles J. Feltton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom</u>	
DATE <u>3/26/56</u>							

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be secured within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-1-56

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01366

## 1497 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7906 KNOLLWOOD RD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u> STREET ADDRESS (If rural give location) <u>7906 KNOLLWOOD RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE ANDREW DAETZ</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>2-9-1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-27-1889</u>
9. AGE last birthday <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER ART DRES.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN DAETZ</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET STECKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-0139</u>	
17. INFORMANT & ADDRESS <u>HELEN M. DAETZ - SAME</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca. of Colon</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>1/24/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Advanced Ca. of Colon</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>November 1953</u> , to <u>2/9/1956</u> , that I last saw the deceased alive on <u>2/9/1956</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Thos. Quinn, M.D.</u>		ADDRESS (Street, city, town, state) <u>TIMONIUM MD 21156</u>	
DATE SIGNED <u>2/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2/13/56</u>	
NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		LOCATION (City, town, or county) (State) <u>BALTO CO. MD.</u>	
24. REC'D BY REGISTRAR DATE: <u>2/13/56</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Jenkins</u>	
ADDRESS <u>4905 YORK RD.</u>			



1498

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Owings Mills</u>	<u>4 yrs. 10 mos.</u>	TOWN <u>Baltimore 31, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>Rosewood St. Tr. School</u>	<u>1740 East Baltimore Street</u>		
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Linda Jean Baird</u>		DATE OF DEATH: <u>February 22, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>2/21/49</u>
9. AGE last birthday: <u>7</u> yrs. <u>7</u> months <u>0</u> days <u>0</u> hours <u>0</u> min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>---</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>William Lloyd Baird</u>		14. MOTHER'S MAIDEN NAME: <u>Joan Winifred Rinehart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>---</u> If Yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS: <u>Rosewood Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Bilateral interstitial pneumonia</u>			<u>Several days</u>
ANTECEDENT CAUSE (B) <u>Repeated aspiration of food.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Brain scars + internal hydrocephalus due to old</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Brain scars + internal hydrocephalus due to old</u>			
19A. DATE OF OPERATION: <u>---</u>		19B. MAJOR FINDINGS OF OPERATION: <u>tubercular meningitis</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>---</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>---</u> , 19 <u>---</u> , to <u>---</u> , 19 <u>---</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>56</u> , and that death occurred at <u>6:15 p.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ruth W. Sneed</u> (Physician)		DATE SIGNED <u>2/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>2/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Edgemoor Cem.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-24-56</u>		REGISTRAR'S SIGNATURE <u>W. J. Deannations</u>	
24. FUNERAL DIRECTOR <u>W. J. Deannations</u>		ADDRESS <u>1740 East Baltimore Street</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

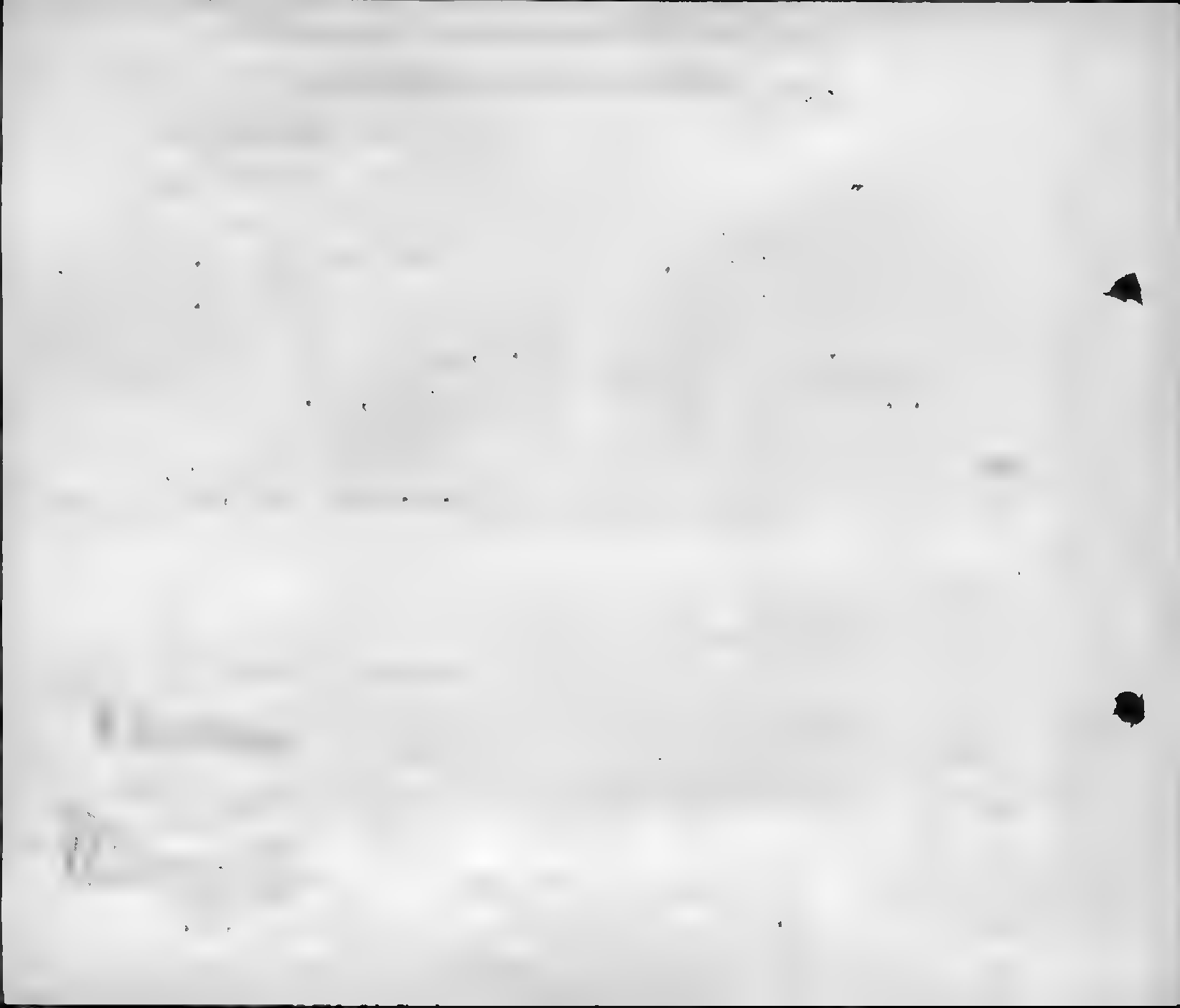
1499

## CERTIFICATE OF DEATH

01368

Reg. Dist. No. 2

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>House in Pines 16 Rusting Ave.</b>				STREET ADDRESS <b>5005 Woodside Rd.</b>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Fannie Beaumont</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 6/56</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>W.</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widow</b>		<b>8. DATE OF BIRTH</b> <b>Sept. 4, 1872</b>	
				<b>9. AGE last birthday</b> <b>83</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>John William Buckingham</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Janet Peacock</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> (Daughter ) <b>Mrs. J. Fred Graves, 5005 Woodside Rd.</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <b>Myocardial Decomensation</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Chronic Cardio-Vascular-Renal Disease</b>						<b>6 yrs</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 9:14 P.M., 1956, to 2:15 P.M., 1956, that I last saw the deceased alive on 8-5, 1956, and that death occurred at 9:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>John F. Gallagher</i>				<b>ADDRESS</b> (Street, city, town, state) <b>M. 6209 Frederick Rd, Balt 28, Md</b>		<b>DATE SIGNED</b> <b>2/7/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb. 9/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Douglas Park</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>T. E. Harry</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Harry H. Witke</i>		<b>ADDRESS</b> <b>4101 Edmondson AVE</b>	
<b>DATE</b> <b>FEB 8 1956</b>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Medical Examiner Certificate*  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** **01369**  
**1410** **CERTIFICATE OF DEATH** **Reg. Dist. No. 43**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Raspeburg</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7936 Oakdale Avenue</u>		STREET ADDRESS (If rural give location) <u>7936 Oakdale Avenue</u>	
3. NAME OF DECEASED. (Type or Print) <u>MARY L. BECKER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 23, 19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Feb. 22, 1898</u>
9. AGE last birthday: <u>58</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Becker</u>		14. MOTHER'S MAIDEN NAME: <u>M. W. Gramder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr. Henry Becker, 7936 Oakdale Ave., Balto. 6</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Pulmonary Embolus</u>			<u>1 hour</u>
ANTECEDENT CAUSE (S) (B) <u>Atherosclerosis of heart</u>			<u>2 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-23-56</u> to <u>2-23-56</u> , that I last saw the deceased <u>alive on 2-23-56</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Jack E. Ballus</u>		DATE SIGNED <u>2-27-56</u>	
ADDRESS <u>Dept Med. Examiner M.D. 2 Kershup Balt</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2/25/56</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 24 '56</u>		REGISTRAR'S SIGNATURE <u>Mrs. M. D. Kershup</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Funeral Home 7401 Belair Rd.</u>	

RECEIVED

FEB 29 1900

BUREAU V. S.

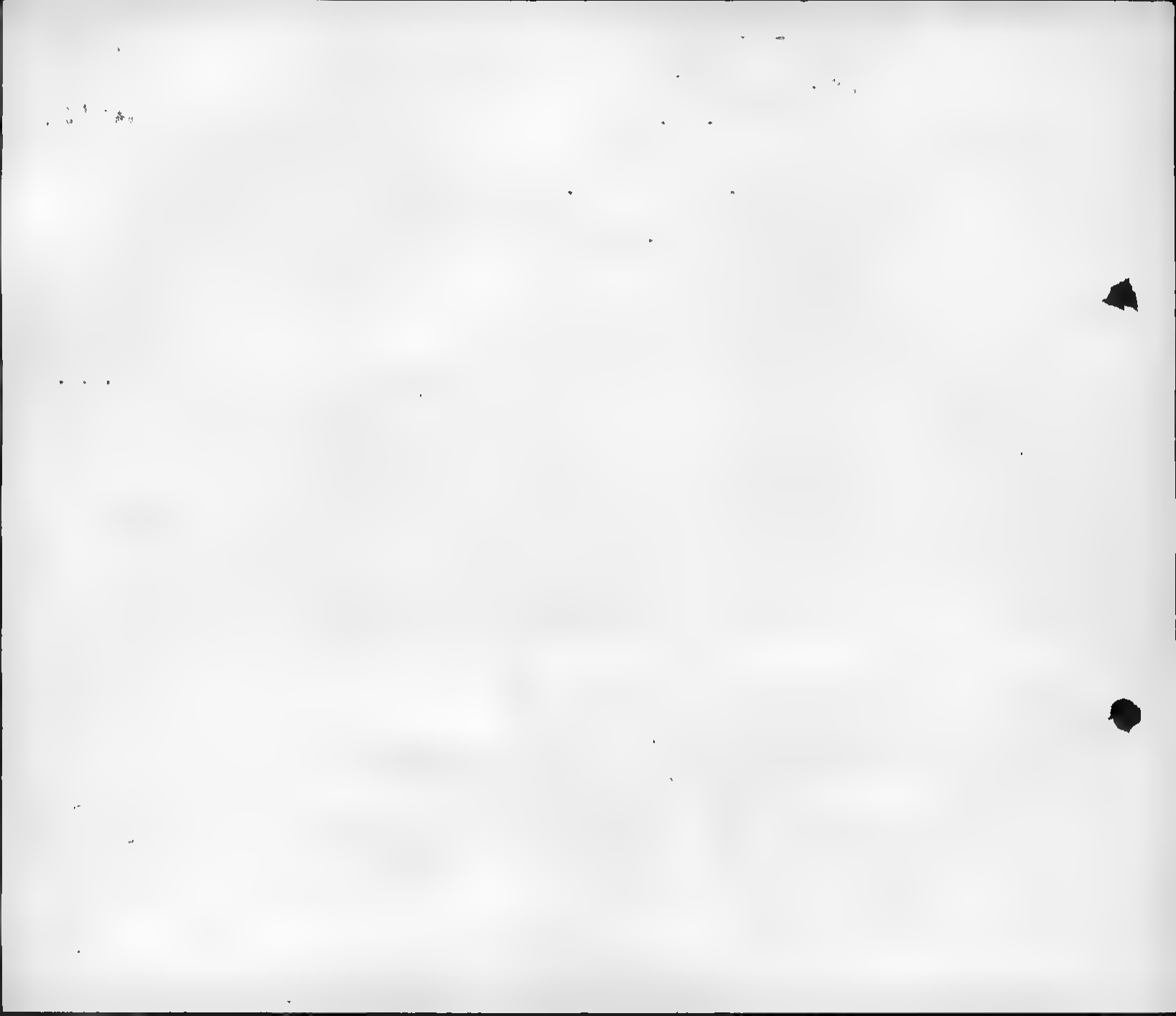
## 1411 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH <b>Rosewood St. Tr. School</b>		2. USUAL RESIDENCE (HOME) OF DECEASED <b>Maryland</b> <b>City</b>	
COUNTY <b>Baltimore</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Owings Mills, Md.</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood State Tr. School</b>	MARYLAND LENGTH OF STAY (in this place) <b>1 1/2 yrs.</b>	STATE <b>Maryland</b> COUNTY <b>City</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Baltimore 15, Maryland</b> STREET ADDRESS (If rural give location) <b>4505 Post Road</b>	
3. NAME OF DECEASED: (Type or Print) <b>Frederick PETER Behm</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>2/29/ 19 56</b>	
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>11/1/13</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
13. FATHER'S NAME: <b>Peter George Behm</b>		14. MOTHER'S MAIDEN NAME: <b>Meta Elizabeth Susemihl-Behm</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT & ADDRESS: <b>Rosewood Records</b>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>492</b> IMMEDIATE CAUSE (A) <b>Pulmonary Edema</b> DUE TO ANTECEDENT CAUSE (B): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <b>Bilateral Pneumonia</b> DUE TO (C) <b>Mongoloid, idiot</b>			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>9/1</b> , 19 <b>54</b> to <b>2/29</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/29</b> , 19 <b>56</b> , and that death occurred at <b>11:00aM</b> , from the causes and on the date stated above. SIGNATURE <i>Carl S. Jank</i> ADDRESS <b>2920 N. CALVERT ST. 2-29-56</b> M.D. DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>MARCH 2, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEM.</b>		LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2-1-56</b>		REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>	
24. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC.</b>		ADDRESS <b>BALTIMORE MD.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,3,4 P. 1 3-93 3-6-56 et

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1412

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH <i>Rosewood Training School</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i> MARYLAND		STATE <i>Maryland</i> COUNTY <i>Pri. Geo.</i>	
CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Suitland</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (if rural give location) <i>P. O. Box 9132</i>	
3. NAME OF DECEASED: (First <i>George</i> (Middle <i>Dean</i> (Last <i>Bennett</i>		4. DATE (Month <i>2</i> (Day <i>25</i> (Year <i>1956</i>	
5. SEX <i>Male</i> 6. COLOR OR RACE <i>white</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>		8. DATE OF BIRTH: <i>5/3/50</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>		9. AGE last birthday IF UNDER 1 YEAR, IF UNDER 20 MRS. Months <i>9</i> Days <i>22</i> Hours <i></i> Min. <i></i>	
10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>unknown</i>	
13. FATHER'S NAME: <i>George Calvin Bennett</i>		14. MOTHER'S MAIDEN NAME: <i>Larocca Aileen Tewell</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT & ADDRESS: <i>Rosewood Training School</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Pneumonia, asphyxiation</i>		3 days	
ANTECEDENT CAUSE (B) <i>Gargoylism</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)		Birth	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/15</i> , 1953, to <i>2/25</i> , 1956, that I last saw the deceased alive on <i>2/24</i> , 1956, and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Dean M. S.</i>		DATE SIGNED <i>25 Feb 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/28/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-27-56</i>		24. FUNERAL DIRECTOR <i>Wm. J. Lickens &amp; Sons - Baltimore, Md.</i>	



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 48 hours after death. Also this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# 1413 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cockeysmill Road</b>				STREET ADDRESS (if rural give location) <b>Cockeysmill Road</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Charles</b> (Middle) <b>F.</b> (Last) <b>Bertsch</b>				(Month) <b>Feb.</b> (Day) <b>10,</b> (Year) <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May, 26, 1877</b>	9. AGE last birthday <b>78</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer Self Employed</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jacob Bertsch</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Hagar</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS <b>Mr. Charles P. Bertsch, Reisterstown</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<b>coronary thrombosis</b>			
ANTECEDENT CAUSE(S) DUE TO (B)				<b>Hypertension &amp; general arteriosclerosis</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<b>Diabetes mellitus</b>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>two years</b> <b>few years</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Night <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1-1-56</b> , <b>1930</b> , to <b>2-10-56</b> , <b>19</b> , that I last saw the deceased alive on <b>1-1-56</b> , <b>19</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>James L. Safell</b>				DATE SIGNED <b>2-11-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 13, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>	
24. REC'D BY REGISTRAR DATE <b>2-12-56</b>		REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Son's Reisterstown, Md.</b>			

BUREAU V. S.

FEB 15 1900

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**INSTRUCTIONS**

**1 TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2 TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01373

# 1414 CERTIFICATE OF DEATH

Reg. Dist. No. 20

<b>1. PLACE OF DEATH</b> COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines 16 Rusting Ave.</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>MD.</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>524 Edgewood St</u>									
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Caroline M. Biemiller</u> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb. 6/56</u> 19									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>		<b>8. DATE OF BIRTH</b> <u>Aug. 21, 1868</u>		<b>9. AGE last birthday</b> <u>87</u> yrs.		<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>None</u>	
<b>13. FATHER'S NAME</b> <u>John Henry Biemiller</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline M. Preisz</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Caleb Dorsey, 3513 Edmondson A</u>					
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>										<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>Coronary occlusion</u>												<u>2 min.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Cardio vascular disease</u>												<u>3 yrs.</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>													
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arterio sclerosis</u>												<u>?</u>	
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>				<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)					
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from</b> <u>May 19 52</u> <b>to</b> <u>Feb. 6</u> <b>19 55</b> , <b>that I last saw the deceased</b> <b>alive on</b> <u>Dec. 30, 19 55</u> , <b>and that death occurred at</b> <u>4 30 P</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Walter Stiebert</u> <b>ADDRESS</b> (Street, city, town, state) <u>M.D. 2220 Garrison Blvd.</u> <b>DATE SIGNED</b> <u>2/7/56</u>													
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>Feb. 9/56</u>				<b>NAME OF CEMETERY OR CREMATORY</b> <u>Laudon Pl. Balto. Md.</u>				<b>LOCATION (City, town, or county)</b> (State)	
<b>24. REC'D BY REGISTRAR</b> <u>FEB 10 1956</u>				<b>REGISTRAR'S SIGNATURE</b> <u>T. E. Harris</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harry H. White</u>				<b>ADDRESS</b> <u>4101 Edmondson</u>	

37



1415  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Catonsville</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>23X-1</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Baltimore</u>	LENGTH OF STAY (in this place) <u>4 yrs 2 mth 1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	STREET ADDRESS (If rural give location) <u>Med. House of Correction, Medwell, Md.</u>		
3. NAME OF DECEASED: (First) <u>Joseph</u> (Middle) <u>Blitzman</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>16</u> <u>1956</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5-24-1898</u>
9. AGE last birthday <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>	11. BIRTHPLACE (State or foreign country): <u>U.S.A. (Maryland)</u>
13. FATHER'S NAME: <u>Michael</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Cardio-vascular disease</u>			
ANTECEDENT CAUSE (B) <u>(Cerebral hemorrhagic?)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 7</u> , 1953, to <u>Feb. 16</u> , 1956, that I last saw the deceased alive on <u>Feb. 16</u> , 1956, and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>L. Dyre Williams</u>		DATE SIGNED <u>2-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombed</u>		DATE THEREOF <u>2/21/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Univ. and Med. School</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>27 1956</u>		24. FUNERAL DIRECTOR ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WILLIAM A. B.

FEB

1917

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **12 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01375

1416 **CERTIFICATE OF DEATH**

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>10 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>New Windsor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIAM</u> (First) <u>P.</u> (Middle) <u>BLOOM, SR.</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 13</u> 19 <u>56</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. RACE OR COLOR</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>		<b>8. DATE OF BIRTH</b> <u>September 5, 1894</u>	
				<b>9. AGE last birthday</b> <u>61</u> yrs		<b>IF UNDER 1 YEAR</b> Months Days	
						<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Buildings</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New Windsor, Maryland</u>	
						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Adam Bloom</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Azealea</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>WW 1</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>RESIDUAL CARCINOMA OF LARYNX WITH METASTASIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Since</u>			
ANTECEDENT CAUSE(S) <del>XXXXX</del> <u>TO LEFT BRACHIAL PLEXUS AND THE CERVICAL VERTEBRAE 1952</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____							
(C) _____							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>6-16-52</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Laryngectomy - Squamous Carcinoma found</u>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>VA</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb. 3, 1956</u>, to <u>Feb. 13, 1956</u>, and that death occurred at <u>5:00 P.</u> M., from the causes and on the date stated above</b>							
<b>SIGNATURE</b> <u>D. D. MARK, M.D.</u>				<b>DATE SIGNED</b> <u>2-14-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2-15-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Presbyterian Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>New Windsor, Maryland</u>	
<b>24. RECORD BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Dawson L. Farley</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook-Blight, Inc.</u>		<b>ADDRESS</b> <u>6009 Harford Rd., Balto. Md.</u>	
<b>DATE</b> <u>Feb. 16, 1956</u>							

4324

RECEIVED

FEB



## 1390 CERTIFICATE OF DEATH

Reg. Dist. No. *42*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>10-7-14</i> OR TOWN <i>10-7-14</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3807 Coolidge Ave</i>				STATE <i>Md</i> COUNTY <i>Baltimore</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>10-7-14</i> OR TOWN <i>10-7-14</i> STREET ADDRESS (If rural give location) <i>3807 Coolidge Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Alfred</i> <i>Boffen</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb 6</i> 1956			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>Apr 29, 1872</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Taylor</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Retired</i>		9. AGE last birthday: <i>83</i> yrs. Months Days Min.		11. BIRTHPLACE (State or foreign country): <i>Germany</i>	
13. FATHER'S NAME: <i>Conrad Boffen</i>				12. CITIZEN OF WHAT COUNTRY? <i>Naturalized U.S.A.</i>			
14. MOTHER'S MAIDEN NAME: <i>Frances W. Boffen</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO <i>220-05-3620</i>				17. INFORMANT & ADDRESS <i>Mrs. Amelia Boffen 3807 Coolidge Ave</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>acute coronary occlusion</i>							
ANTECEDENT CAUSE (B) <i>chronic myocarditis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>hypertension</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Senility</i>							
19A. DATE OF OPERATION: <i>C</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 5, 1956</i> , to <i>Feb 6, 1956</i> that I last saw the deceased alive on <i>Feb 6, 1956</i> , and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Dr. J. B. Boffen</i>		ADDRESS <i>3807 Coolidge Ave</i>		DATE SIGNED <i>4/6/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>2-4-56</i>		NAME OF CEMETERY OR CREMATORY <i>Union</i>		LOCATION (City, town, or county) (State) <i>Howard Co Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7/3/56</i>		REGISTRAR'S SIGNATURE <i>Dr. J. B. Boffen</i>		24. FUNERAL DIRECTOR <i>Howard Co</i>		ADDRESS <i>4107 W. ...</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1417

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH. <u>Rosewood Training School</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Stomewy</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills.</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>	<u>15-11-22</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood St. Tr. Sch.</u>		STREET ADDRESS (If rural give location) <u>6506</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Albert Francis Bonifant</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb 25, 1956</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10/24/19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Thomas Bonifant</u>		14. MOTHER'S MAIDEN NAME: <u>Eve L. Gittings Bonifant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Eva L. Bonifant 6605</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
178X IMMEDIATE CAUSE (A) <u>Malignant tumor of chest.</u>			
ANTECEDENT CAUSE (S) DUE TO <u>COMPRESSION OF TRACHEA AND HEART FAILURE</u>			
(B) DUE TO <u>EXTENSIVE METASTASES OF SEMINOMA.</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION. <u>11-7-55-</u>		19B. MAJOR FINDINGS OF OPERATION <u>Seminoma RT Testicle.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 2, 1955</u> , to <u>Feb 25, 1956</u> , that I last saw the deceased alive on <u>2/25/</u> , 1956, and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>2/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 28, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Rosewood St. Tr. Sch. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-27-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>2046</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU OF

MAR 5 1955

RECEIVED



1418

## CERTIFICATE OF DEATH

01378

Item 14, Film G193 2-23-56 et

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Kingsville</b>				TOWN <b>Kingsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Belair Rd. &amp; Cherrol Road</b>				STREET ADDRESS (If rural give location) <b>Belair Road &amp; Cherrol Road</b>			
3. NAME OF DECEASED (Type or Print) <b>Elizabeth</b> (First) (Middle) (Last) <b>Bose</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 15 1956</b>			
5. SEX <b>F</b>	6. CO. OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Nov. 3, 1868</b>	9. AGE last birthday <b>87</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Kniesche</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Kingsville, Md. Mrs. Margaret Gonnson, Belair &amp; Cherrol</b>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <b>Coronary occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>45 min.</b>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized Arteriosclerosis</b>						<b>20+ yrs.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 1954</b> , to <b>Feb. 15 1956</b> , that I last saw the deceased alive on <b>Feb. 15 1956</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>William A. Tyson</b> M.D.				ADDRESS (Street, city, town, state) <b>Kingsville, Md Feb 15 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 18, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR <b>FB 17 1956</b>		REGISTRAR'S SIGNATURE <b>Mrs. G. L. Reppert</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

MINIMUM DIRECTIONS: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1990

**INSTRUCTIONS**  
1  
The bottom copy may be retained by the hospital or attending physician.  
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 415C 1-55 10M

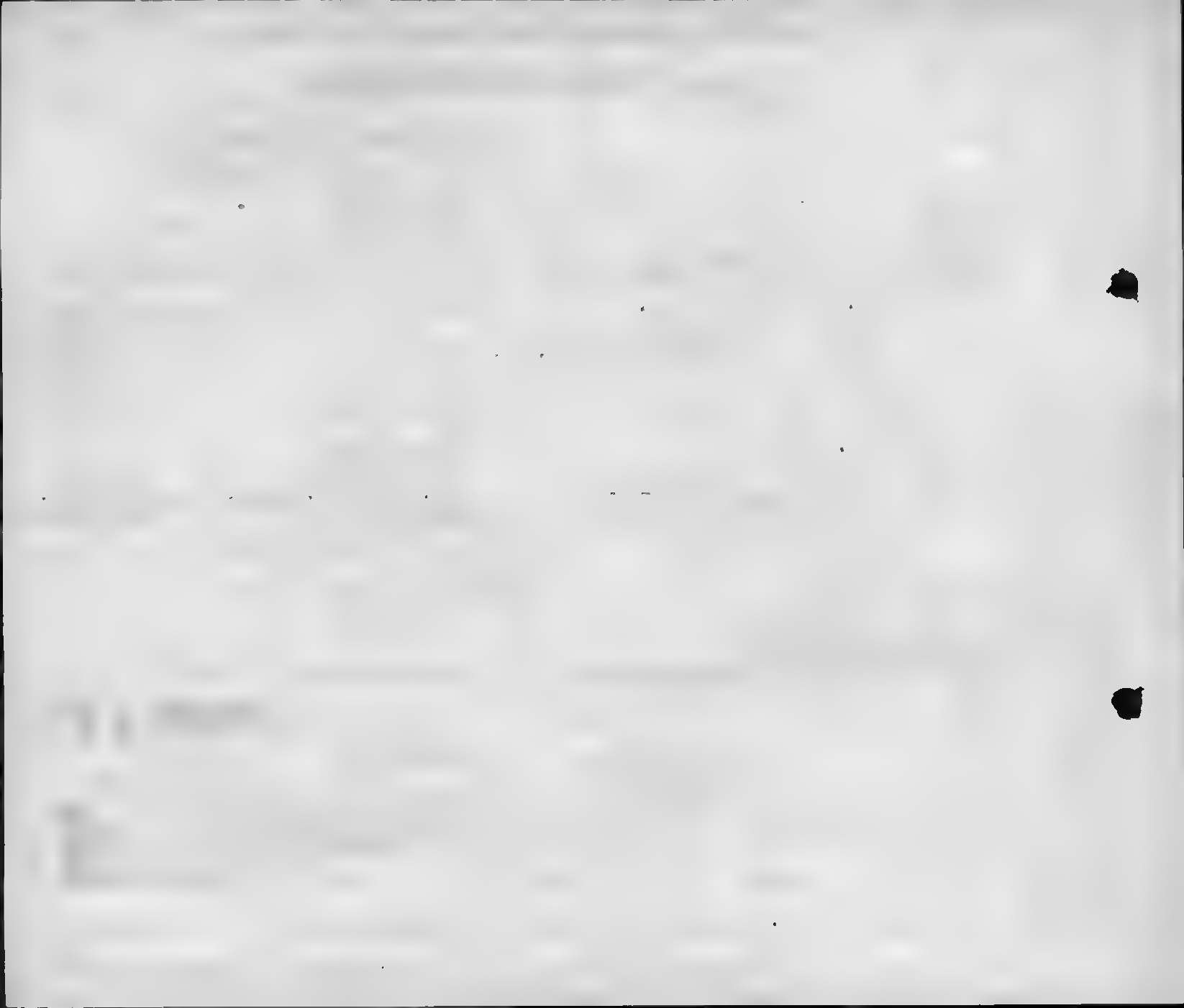
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01379

1419 **CERTIFICATE OF DEATH**

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>4 White Thorn Way</b>				STREET ADDRESS (If rural give location) <b>4 White Thorn Way</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mr. William C. Brandau</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>February 2nd 1956</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>		<b>8. DATE OF BIRTH</b> <b>Feb. 16, 1885</b>	
<b>9. AGE last birthday</b> <b>70 yrs.</b>		<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Baltimore, Maryland</b>	
<b>13. FATHER'S NAME</b> <b>William O. Brandau</b>				<b>14. MOTHER'S MARDEN NAME</b> <b>Florence Rush</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>215-22-5651</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Myrtle B. Young, 44 Kingston Rd.</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <b>Coconary Occlusion</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>6 hours</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arterio-sclerotic cardiovascular disease</b>						<b>5 years</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Feb., 1954, to Feb., 1956, that I last saw the deceased alive on Feb., 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Corio Semeroff</b>				<b>ADDRESS (Street, city, town, state)</b> <b>M.D. 1437 Fiske Ave Baltimore, Md.</b>			
<b>DATE SIGNED</b> <b>2/2/56</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb. 6, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>FEB 5 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Mrs. Edith Hurley</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #11</b>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1420

## CERTIFICATE OF DEATH

01380

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3003 ACTON RD</u>				STREET ADDRESS (If rural, give location) <u>3003 ACTON RD</u>			
3. NAME OF DECEASED (Type or Print) <u>SUSAN</u>		(First) <u>P</u>		(Last) <u>BRANDT</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>19</u> (Year) <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <del>SINGLE, MARRIED,</del> WIDOWED, <del>DECEASED,</del> (Specify)		8. DATE OF BIRTH <u>JAN 17, 1894</u>	9. AGE last birthday <u>62</u> yrs.	If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRESS SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>				13. FATHER'S NAME <u>JOHN BRANDT</u>			
14. MOTHER'S MAIDEN NAME <u>SUSAN LUTTMAN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY No.				17. INFORMANT <u>LEWIS C. BRANDT 3003 ACTON RD</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cirrhosis of liver</u>						<u>6 mos</u>	
Antecedent cause(s) (b) <u>Hemiplegia</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last						<u>18 mos</u>	
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>				(STATE)			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 14</u> , 1956, to <u>Feb 19</u> , 1956, that I last saw the deceased alive on <u>Feb 18</u> , 1956, and that death occurred at <u>6:50 P</u> m., from the causes and on the date stated above.							
SIGNATURE <u>G. M. Bacon M.D.</u>				ADDRESS <u>2810 Taylor Cere</u> DATE SIGNED <u>2/20/56</u>			
23. BURIAL, CREMATION OR DISPOSITION (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Feb 23 1956</u>		<u>GREEN MOUNT Cemetery</u>		<u>YORK Penn</u>	
DATE REC'D BY LOCAL REG. <u>2/20/56</u>		REGISTRAR'S SIGNATURE <u>G. M. Bacon</u>		24. FUNERAL DIRECTOR <u>CHAS. F. EVANS &amp; SON 8802 HARFORD RD.</u>			

BUREAU V. S.

FEB 9 1901

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the names of death clearly and legibly.

1421

01381

Reg. Dist. 45

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River Helen pt</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Middle River Helen pt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beech Drive</u>		STREET ADDRESS (If rural, give location) <u>Beech Drive zone 20.</u>	
3. NAME OF DECEASED: (First) <u>August</u> (Middle) <u>Bremer Jr</u> (Last) <u>Bremer Jr</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>single</u>	8. DATE OF BIRTH: <u>May 16 1912</u>
9. AGE last birthday: <u>43</u> yrs		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Livery Str</u>	
11. BIRTHPLACE (State or foreign country): <u>N. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>August Bremer</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca Forsuch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>W.W.II</u>		16. SOCIAL SECURITY No.: <u>216-10-3199</u>	
17. INFORMANT & ADDRESS: <u>See Bremer, 7334 Berkshire Rd.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u> DUE TO			30 Min
Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town; (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. TIME (Month) (Day) (Year) (Hour) OF INJURY		21f. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Jack P. Keller</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REG. <u>2/9/6</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	
NAME OF CEMETERY OR CREMATORY <u>Map Lawn Cem</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
ADDRESS <u>7401 Belair Rd</u>			





1422

## CERTIFICATE OF DEATH

01382

Reg. Dist. No.

Item 8, Film G193 3-6-56 et

## 1 PLACE OF DEATH.

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) (in this place)  
TOWN CatonsvilleHOSPITAL OR  
INSTITUTION OR Home In the Pines.  
STREET ADDRESS 16 Fustling Ave.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto.  
CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN CatonsvilleSTREET  
ADDRESS (If rural give location)  
156 Sanford Road3. NAME OF  
DECEASED:  
(Type or Print)(First) (Middle) (Last)  
Joseph M. Beckhawn4 DATE  
OF  
DEATH: Feb. 25 19 56  
(Month) (Day) (Year)

## 5. SEX:

6 COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)8. DATE OF BIRTH:  
22 1866  
Nov. 24 18669. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  
89 yrs. Months Days Hours Min.10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

11 BIRTHPLACE (State or foreign country):

12 CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME:

James L. Beckhawn

## 14. MOTHER'S MAIDEN NAME:

Mary E. Wright15 WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service):no

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Mary Hazel Beckhawn

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

LOBAR PNEUMONIA

DUE TO

Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b)

CEREBRAL APOPLEXY LEFT HEMIPLEGIA- 2 MO.

DUE TO

(c)

SENILITY AND ARTERIOSCLEROSIS. Years

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY 0 m.INJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Jan, 17, 19 56, to Feb, 25, 19 56 that I last saw the deceased

alive on FEB, 24, 19 56, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/28/56J. C. YoungH. B. Whippert - 1700 E. Eitaw Pl.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1423  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01383  
Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Middle River - 21</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>BALTO. CO. MIDDLE RIVER.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>49 DENTON ROAD.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>CLAYTON</u>		(Middle) <u>I</u>		(Last) <u>BROWN</u>		(Month) (Day) (Year) <u>Feb 20 1946</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>BLACK</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>Sept 7-1873</u>	
9. AGE last birthday: <u>82</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>ENGINEER</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>CLARA R. BROWN 49 DENTON ROAD</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) .... <u>Chronic myocarditis</u> DUE TO							?
Antecedent cause(s) (b) .... <u>Sexuality</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town, (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>				M. D. ASSISTANT MEDICAL EXAM. <u>[Signature]</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>2/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		LOCATION (City, town, or county) (State) <u>WINDSOR MILL RD.</u>	
DATE REC'D BY LOCAL REG. <u>Feb-21-1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>3615 N. Chestnut Ave.</u>	



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

It- 2 Film G193 2-27-56

# CERTIFICATE OF DEATH

Reg. Dist. No... 37.

*Masonic Home, Cockeysville, Md.*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Cockeysville</i>		LENGTH OF STAY (in this place) <i>1 mos</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		TOWN <i>Cockeysville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS <i>308 Citings</i> (If rural give location) <i>Cockeysville, 2934-Baltimore</i>			
3. NAME OF DECEASED (Type or Print) <i>Katherine Marie Buck</i>				4. DATE OF DEATH <i>Feb 7 1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Feb. 27, 1877</i>	
9. AGE last birthday <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>							
13. FATHER'S NAME <i>Edward Buckner</i>				14. MOTHER'S MAIDEN NAME <i>James Campbell 11 children</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Edna Buckner, Masonic Home</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <i>7 mos.</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>coronary thrombosis</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 14 1955</i> to <i>Feb 7 1956</i> , that I last saw the deceased alive on <i>Feb 7 1956</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Valter T. Kees</i>				DATE SIGNED <i>2/7/56</i>			
M.D.				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/10/56</i>		NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		LOCATION (City, town, or county) (State) <i>Woodlawn Maryland</i>	
24. REC'D BY REGISTRAR <i>Frank Smith</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Book Inc</i>		ADDRESS <i>1217 H Paul St</i>	
DATE <i>FEB 9 1956</i>							



1425

## CERTIFICATE OF DEATH

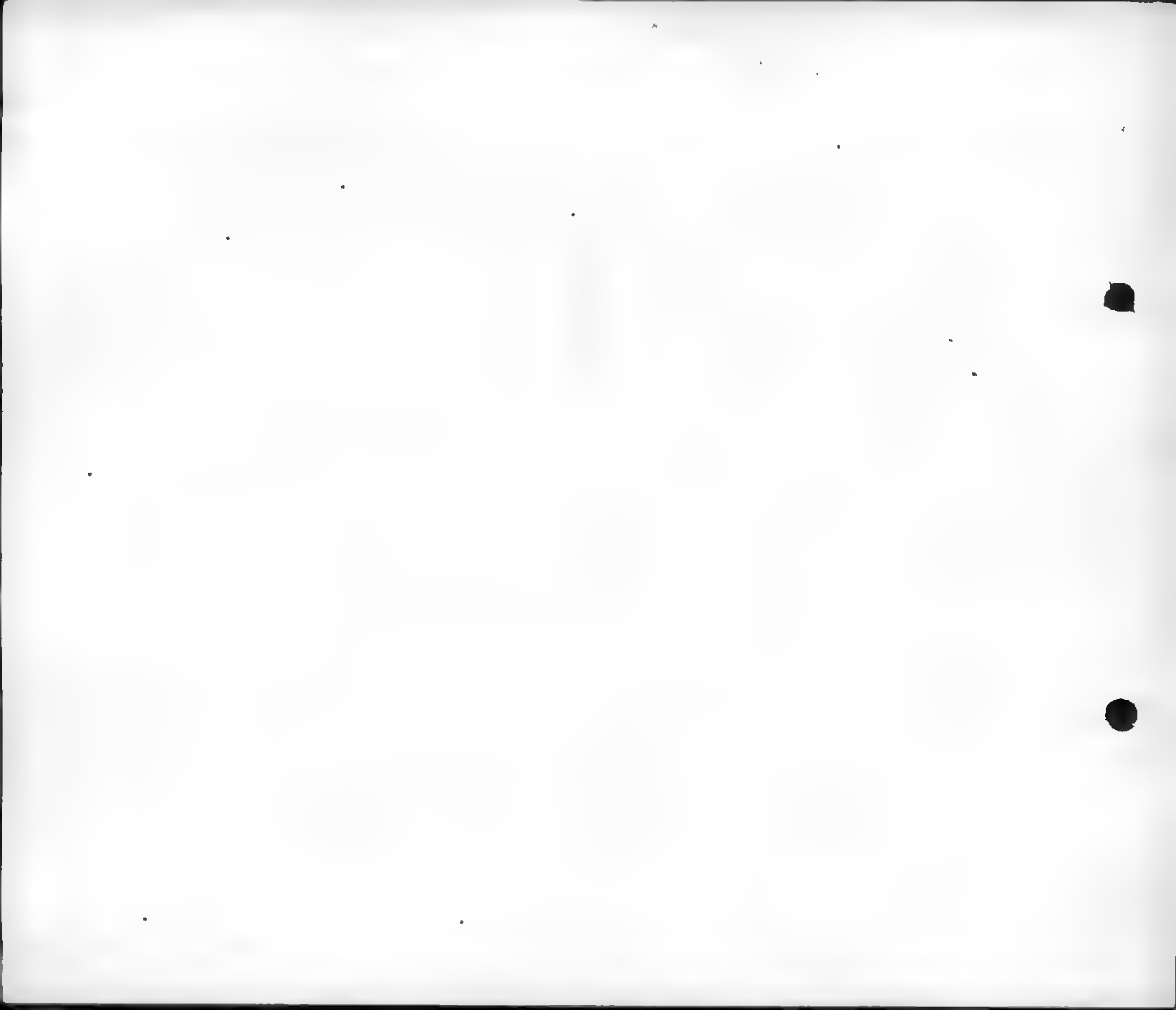
Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Balto.</u> MARYLAND			STATE <u>Md.</u> COUNTY		
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) TOWN <u>Catonsville</u> (in this place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto.</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smithwood &amp; Summit Ave. Wayne Nursing Home</u>			STREET ADDRESS (If rural give location) <u>2110 Bolton St.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>ANNA MARIE BUECHNER</u>			<u>FEB 10 1956</u>		
5. SEX: FEMALE			6. AGE last birthday: <u>78</u> yrs.		
7. COLOR OR RACE: WHITE			8. DATE OF BIRTH: <u>Oct. 21, 1877</u>		
9. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>			10. AGE last birthday: <u>78</u> yrs.		
10a. USUAL OCCUPATION Give kind of work done during most of working life, (if retired):			10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		
11. BIRTHPLACE (State or foreign country): <u>Germany</u>			12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>		
13. FATHER'S NAME: <u>John Malsy</u>			14. MOTHER'S MAIDEN NAME: <u>Kunigunda Hefner</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.: <u>Mr. Alexander Buechner-2110 Bolton S. t.</u>		
17. INFORMANT & ADDRESS:					

11. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) DUE TO <u>Fracture Hip Right</u>					
Antecedent causes (s) (b) DUE TO <u>Diabetes Mellitus</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Decubitus Ulcers Extensive</u>					
<u>Senile Dementia</u>					
Interval Between Onset And Death <u>2 1/2 months</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>Nov 2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		(CITY OR TOWN) <u>Spring Grove State Hosp.</u> COUNTY <u>Catonsville</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11/17/55</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Fell out of Bed</u>	
22. I hereby certify that I attended the deceased from <u>1 Feb., 1956</u> to <u>10 Feb., 1956</u> , that I last saw the deceased alive on <u>8 Feb., 1956</u> , and that death occurred at <u>7:45 PM.</u> from the causes and on the date stated above.					
SIGNATURE <u>W. L. Smith M.D.</u>		(Degree or title)		ADDRESS <u>1707 Edmondson Ave. Catonsville 28md</u> DATE SIGNED <u>2/10/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>2/13/56</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount Crem.</u> LOCATION (City, town, or county) <u>Balto., Md.</u> (State)	
DATE REC'D BY LOCAL REGISTRAR <u>February 11, 1956</u>		REGISTRAR'S SIGNATURE <u>R. W.</u>		24. FUNERAL DIRECTOR <u>Wm. J. Lohmeyer &amp; Sons - Balto 17 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





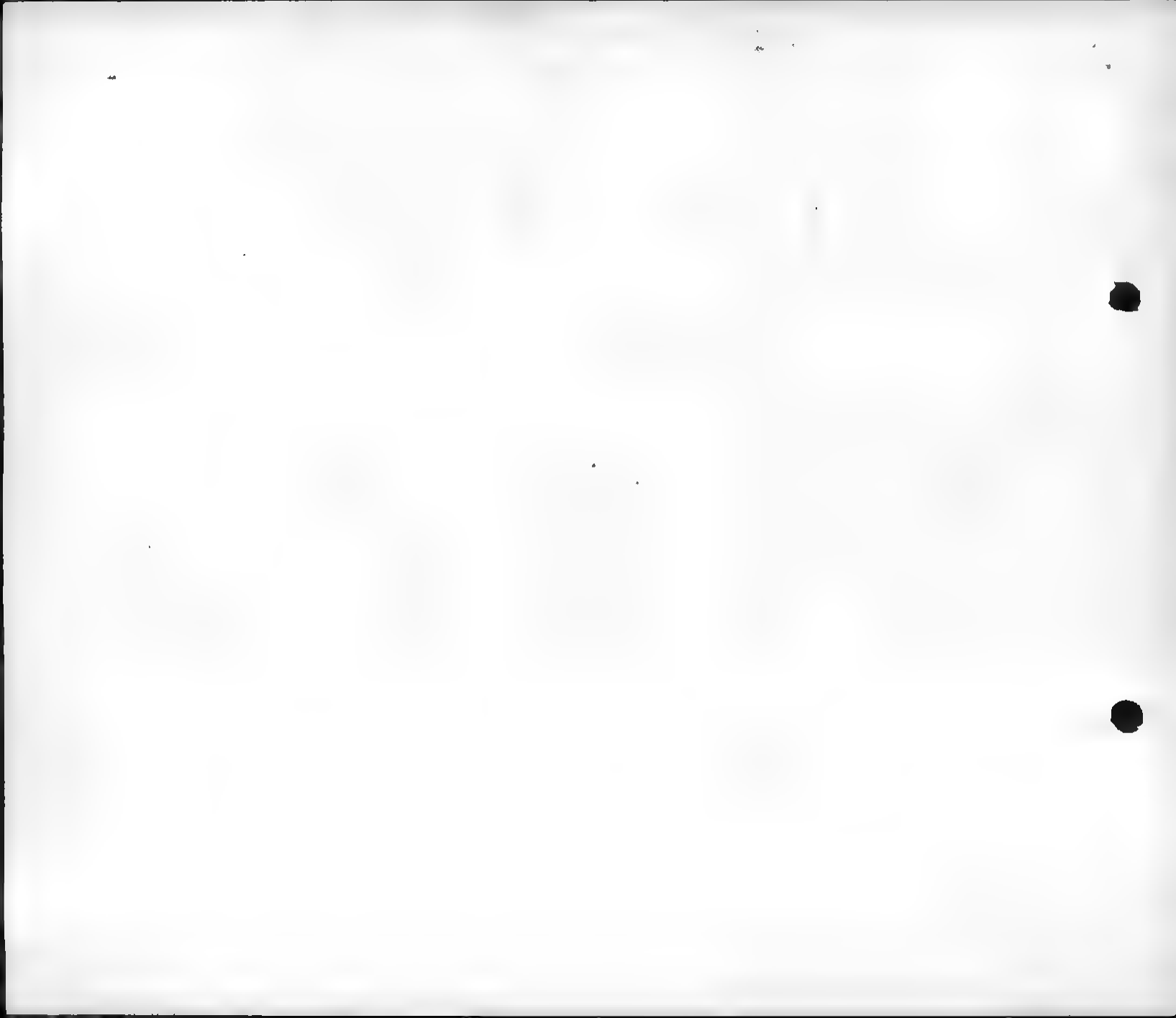
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01386

1426 *Baltimore*  
*Catonsville* CERTIFICATE OF DEATH

Reg. Dist. No. *32*

1. PLACE OF DEATH: COUNTY <i>Catonsville</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>White Marsh</i> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove Hospital</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>White Marsh</i> STREET ADDRESS (If rural give location) <i>13 Bird River Grove Rd.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>MABLE LOUISE CARDWELL.</i>		4. DATE (Month) (Day) (Year) OF DEATH. <i>Feb 22 1956</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>Sept 1, 1886</i>
9. AGE last birthday: <i>69</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>	11. BIRTHPLACE (State or foreign country): <i>Balto, Md.</i>
12. CITIZEN OF WHAT COUNTRY: <i>USA</i>		13. FATHER'S NAME: <i>Howard Rigg</i>	
14. MOTHER'S MAIDEN NAME: <i>Isabelle Heaton</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <i>No</i> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.: <i>213-10-1206</i>		17. INFORMANT & ADDRESS: <i>Eleanor Marshall White Marsh, Md.</i>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Acute Myocardial Infarction (Post)</i>			
ANTECEDENT CAUSE (B) <i>Diabetes Mellitus</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE LAST. (C) <i>Generalized Atherosclerosis with</i>			
		<i>Myocardial and Cardiac enlargement</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <i>June 10, 1955</i> , to <i>Feb 22, 1956</i> , that I last saw the deceased alive on <i>Feb 22, 1956</i> , and that death occurred at <i>11 P. M.</i> from the causes and on the date stated above.			
SIGNATURE <i>J. R. Cowen</i>		DATE SIGNED <i>2/22/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>2/25/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Meadow Ridge</i>		LOCATION (City, town, or county) (State) <i>Relay Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-24-56</i>		REGISTRAR'S SIGNATURE <i>J. R. Cowen</i>	
24. FUNERAL DIRECTOR'S NAME, ADDRESS <i>John S. Anderson &amp; Son, Inc. Balto. Md.</i>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1427  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02531  
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson LENGTH OF STAY (in this place)  
HOSPITAL OR INSTITUTION OR STREET ADDRESS 922 Roland View Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore 1  
STREET ADDRESS (If rural, give location) 507 Myrtle Avenue

3. NAME OF DECEASED:  
(Type or Print)

(First) WALTER (Middle) AL EXANDER (Last) CARROLL

4. DATE OF DEATH (Month) (Day) (Year)  
2 9 56

5. SEX:

Male

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED.  
(Specify): Married

8. DATE OF BIRTH:

Feb. 19, 1904

9. AGE last birthday: 51 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:  
Private-Family

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No:

17. INFORMANT & ADDRESS:

Maggie Carroll-

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

Immediate cause

(a) DUE TO

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
DEPUTY MEDICAL EXAMINER ☐  
M. D. ASSISTANT MEDICAL EXAM. ☒

2/19/56

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

2/12/56

NAME OF CEMETERY OR CREMATORY

Baltimore Nat

LOCATION (City, town, or county)

Baltimore Md.

(State)

REGISTRAR'S SIGNATURE

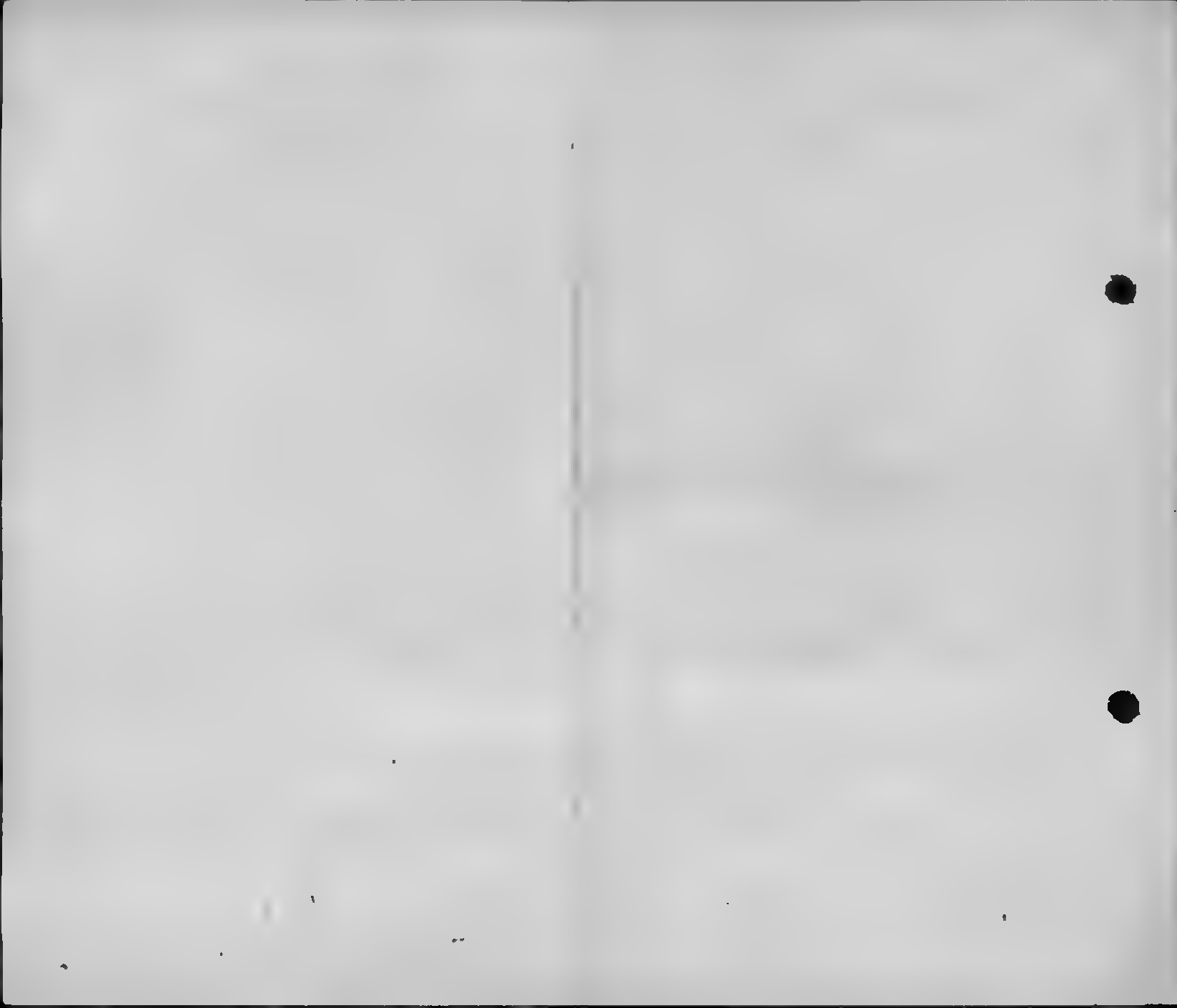
[Signature]

24. FUNERAL DIRECTOR

Chas. O. Wilson

ADDRESS

1000



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01387

## 1428 CERTIFICATE OF DEATH

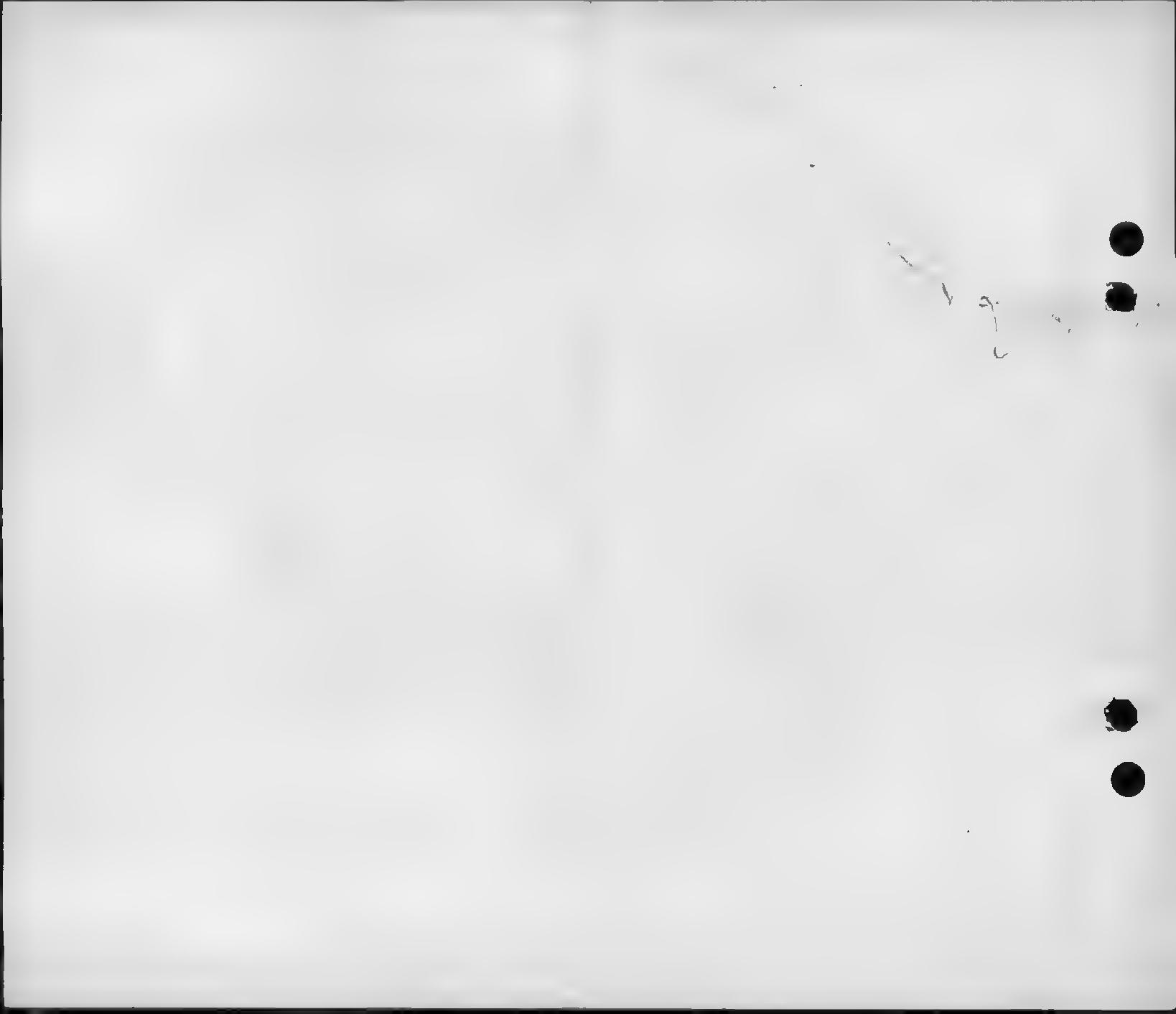
Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTO. CO.</u> MARYLAND <u>MD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>RURAL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MT. WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6112 FALLS RD.</u>		STREET ADDRESS (If rural, give location) <u>6112 FALLS RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>Robt. FRANKLIN (ARTER)</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>APR 4 - 1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE'S Shop</u>	9. AGE last birthday <u>55</u> yrs. <u>10</u> Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Richmond VA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN CARTER</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>FOR DE MOME 10 MAR 1942</u>		16. SOCIAL SECURITY No. <u>214-202975</u>	
17. INFORMANT AND ADDRESS <u>Wife</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
Immediate cause (a) <u>Coronary Occlusion</u>			
Antecedent cause(s) (b) <u>Diabetes</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Obesity</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>246</u> - <u>1956</u> , to <u>216</u> - <u>1956</u> , that I last saw the deceased alive on <u>2-16</u> - <u>1956</u> , and that death occurred at <u>9:30 PM</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Chas. Victor Lieber</u>		ADDRESS <u>321 Deer Run Rd. Bz 21616</u>	
DATE SIGNED <u>2/16/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIED</u>		DATE THEREOF <u>2/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		LOCATION (City, town, or county) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Wm. I. CHATMAN, JR.</u>	
FUNERAL DIRECTOR <u>1701 Mt. Calvert St.</u>		ADDRESS <u>BALTO. MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



1429

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 12, File 293 3-5-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Brooklandville,</b>		<b>28 yrs.</b>		TOWN <b>Brooklandville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Falls Road</b>				STREET ADDRESS (If rural give location) <b>Falls Road</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<b>MARJORIE ALICE CASSELL</b>				<b>Feb. 20, 1956</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<b>Female</b>	<b>White</b>	<b>married</b>	<b>March 30, 1880</b>	<b>75 yrs.</b>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife</b>				<b>Worcester, England</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Alfred Lucardo Wells</b>				<b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>No</b>		<b>None</b>		<b>W. Barry Cassell, Brooklandville, Md.</b>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<b>Cerebral Vascular Accident</b>			
ANTECEDENT CAUSE(S) DUE TO (B)				<b>Arteriosclerotic Cardio-vascular disease</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				INTERVAL BETWEEN ONSET AND DEATH			
				<b>10 days</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug 15, 1955</b> to <b>Feb 20, 1956</b> that I last saw the deceased alive on <b>Feb 20, 1956</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Waverly S. Green, Jr.</b>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<b>M.D. 1725 Reisterstown Road</b>		<b>Feb. 21, 1956</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Cremation</b>		<b>Feb. 22, 1956</b>		<b>Green Mount Crematory</b>		<b>Baltimore, Maryland</b>	
24. REMD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>FEB 24 1956</b>		<b>Mrs. Mabel Gray</b>		<b>John O. Mitchell &amp; Sons Inc.,</b>		<b>1900 Eutaw Pl.</b>	

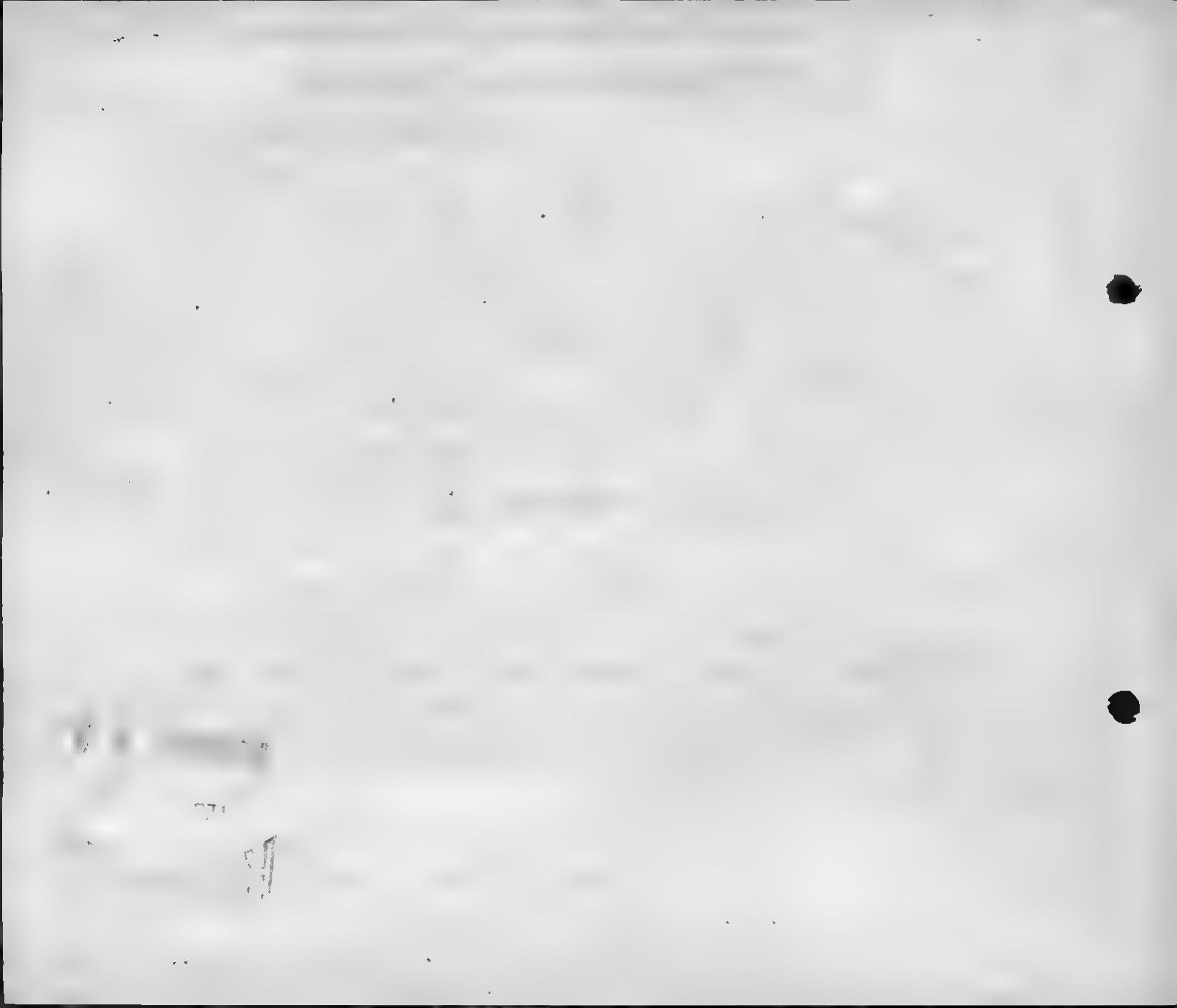
Waverly Green

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M





## 1430 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>57 TOWN Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u> <u>5743 Edmondson Ave.</u>		STREET ADDRESS (If rural give location) <u>922 S. Charles St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>BERTHA</u>	(Middle) <u>A.</u>	(Last) <u>CHAMOW</u>	(Date) <u>Feb. 26, 1956</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb. 22, 1896</u>
9. AGE last birthday <u>60</u> yrs		10. AGE UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Charles H. Heintzeman, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Amelia Yeakle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Clifton Park</u> <u>Mr. Charles H. Heintzeman-Lake Cottage</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE		(A) <u>Coronary Occlusion</u>	
ANTECEDENT CAUSE (B)		DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		DUE TO (C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> , 19, to <u>Feb. 26, 1956</u> , that I last saw the deceased alive on <u>Feb. 26, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ray M. Zimmerman</u>		ADDRESS <u>M. D. 3262 Hanford Rd</u> DATE SIGNED <u>Feb. 27, 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/29/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		LOCATION (City, town, or county) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-28-56</u>		REGISTRAR'S SIGNATURE <u>Wm. J. [Signature]</u> FUNERAL DIRECTOR <u>[Signature]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01330

1431

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH: Baltimore  
 County Baltimore  
 City or town Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 18 Years  
 Hospital, institution, or street address where death occurred.  
1909 Kernan Drive  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1909 Kernan Drive  
 (If rural, give LOCATION)  
 2.(a) If veteran, name-war NONE

3.(a) FULL NAME CHARLES EMORY CHEUVRONT

3.(b) Social Security Number  
705-03-8042

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Stephanie L. Cheuvront  
 7. Birth date of deceased (mo., day, yr.) September, 20th, 1903  
 8. AGE: Years 52 Months 4 Days 26 If less than one day hrs. min.

9. Birthplace Dickeyville, Balto. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Ass't Chief Clerk  
 11. Industry or business B. & O. R. R.  
 12. Name Charles William Cheuvront  
 13. Birthplace Martinsburg, West. Va.  
 14. Maiden name Ledie Electra Devese  
 15. Birthplace Woodlawn, Balto. Co. Md  
 16. Informant Mrs Charles Emory Cheuvront  
 Address 1909 Kernan Drive ( 7 )

17. Burial Feb. 20, 1956  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Lorraine Park Cemetery  
 Location Woodlawn, Balto. Co. Maryland  
 18. Funeral director Charles Lamoreau  
 Address 4510 Liberty Heights Avenue (7)

19. February 15, 1956  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH February, 16th., 1956 3.30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 8, 1955 to Feb. 15, 1956  
 and that I last saw him alive on Feb. 15, 1956

Immediate cause of death Coronary thrombosis DURATION 5 min.

Due to Cardio vascular disease 2 mos.

Due to Arterio sclerosis 1

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles W. Tublitt

Address 2220 Garrison B'ld. Date signed Feb. 17/56

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01391

## 1432 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Sparks</i>		<i>37 yrs</i>		TOWN <i>Sparks</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Belfast Road</i>				STREET ADDRESS (If rural give location) <i>Belfast Rd.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Charles</i> (Middle) <i>Brooks</i> (Last) <i>Chilcoat</i>				(Month) <i>February</i> (Day) <i>3</i> (Year) <i>1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>29 June 1918</i>	<i>67</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Farmer</i>		<i>Farming</i>		<i>Sparks Balto. Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME <i>George Chilcoat</i>				14. MOTHER'S MAIDEN NAME <i>Ruth Brooks</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>228-09-4544</i>		<i>Wife - Same</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<i>3 days</i>			
IMMEDIATE CAUSE (A) <i>Coronary thrombosis</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardio-vascular disease</i>				<i>8 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1948</i> to <i>February</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3 Feb</i> , 19 <i>56</i> , and that death occurred at <i>11 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Kees</i>				DATE SIGNED <i>3 February 1956</i>			
M.D. <i>Cockeysville Md.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2-6-56</i>		<i>Bosleys Methodist</i>		<i>Sparks, Balto. Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>6 Feb 1956</i>		<i>Nene Armistead MacRae</i>		<i>L. Scott Brooks</i>		<i>Sparks, Md.</i>	



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01392

## 1433 CERTIFICATE OF DEATH

Reg. Dist. No. 33

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY <u>Parkton</u> OR TOWN <u>Rural</u>		CITY <u>Parkton</u> OR TOWN <u>Rural</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Parkton</u>		<u>12 yrs</u>		TOWN <u>Parkton</u>		TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt Carmel</u>				STREET ADDRESS (If rural give location) <u>Mt Carmel</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Effie</u> (Middle) <u>Pearl</u> (Last) <u>Chilcoat</u>				(Month) <u>February</u> (Day) <u>11</u> (Year) <u>1956</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>July 22, 1887</u>	
<b>9. AGE last birthday</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>68</u> yrs.		<u>Housewife</u>		<u>MARYLAND</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or upk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<u>Nicholas Mays</u>		<u>Margaret Wilhelm</u>		<u>NO</u>		<u>Aldridge Chilcoat, Parkton Md</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Carcinoma Rectum-Primary</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>			
<input type="checkbox"/>				<u>---</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>JAN 4</u>, 19<u>55</u>, to <u>February 11</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb. 11</u>, 19<u>56</u>, and that death occurred at <u>11:30 A.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Joseph V. Bush M.D.</u>				<b>DATE SIGNED</b> <u>2/11/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>Burial</u>				<u>2-14-56</u>			
<b>DATE OF OPERATION</b>				<b>NAME OF CEMETERY OR CREMATORY</b>			
<u>Feb 14/56</u>				<u>Salena W.B.</u>			
<b>LOCATION (City, town, or county)</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Balto Co Md</u>				<u>Edw. E. Dwyer</u>			
<b>ADDRESS</b>				<b>ADDRESS</b>			
<u>Hampstead Md</u>				<u>Hampstead Md</u>			

2. 14-26 Word E 3/1000



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

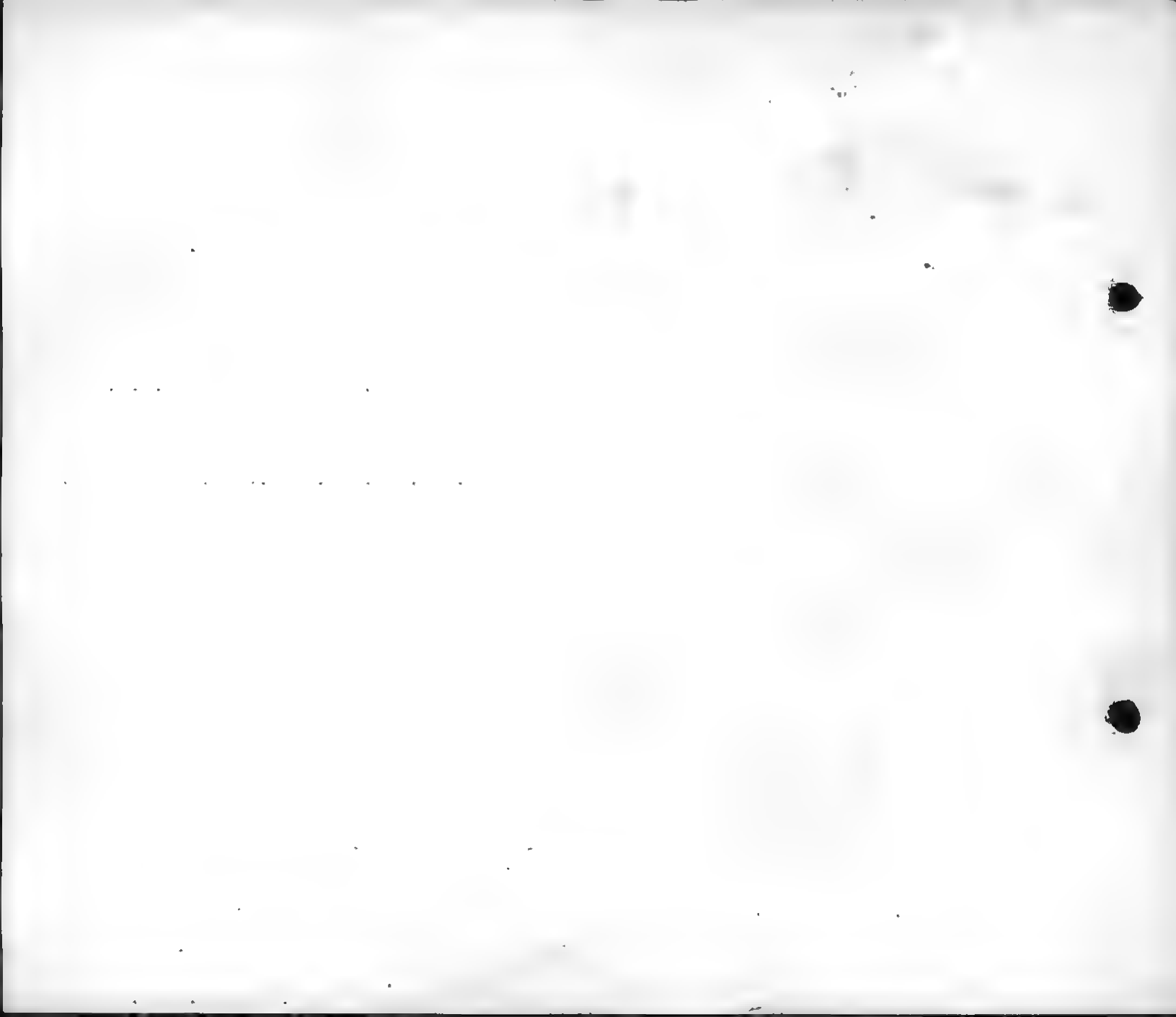
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01393

## 1434 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write and give nearest town) <u>PORT HOWARD</u>		CITY (If outside corporate limits, write and give nearest town) <u>BALTIMORE</u>	
RURAL LENGTH OF STAY OR TOWN <u>135 7/8 Days</u>		RURAL and give nearest town) <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>2746 WINCHESTER St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES (NMI) CLEVELAND</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 24 19 56</u>	
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>COLORED</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>8/14/1892</u>	
9. AGE last birthday: <u>65</u> yrs. <u>68</u> Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country): <u>UNION, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOHN CRAWFORD CLEVELAND</u>		14. MOTHER'S MAIDEN NAME: <u>ALANA NOTCH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY NO. <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>	
17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>0021</u>		UNKNOWN	
(B) ANTECEDENT CAUSE (S) <u>FAR ADVANCED TUBERCULOSIS LEFT LUNG</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>VA</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 20, 19 56</u> to <u>Feb. 24, 19 56</u> , and that death occurred at <u>7:15 P M</u> , from the causes and on the date stated above.			
SIGNATURE <u>DONALD D. MARK, M. D.</u>		DATE SIGNED <u>2/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law Funeral Home 802-04 Madison Ave., Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-27-56</u>		REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55-7040

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

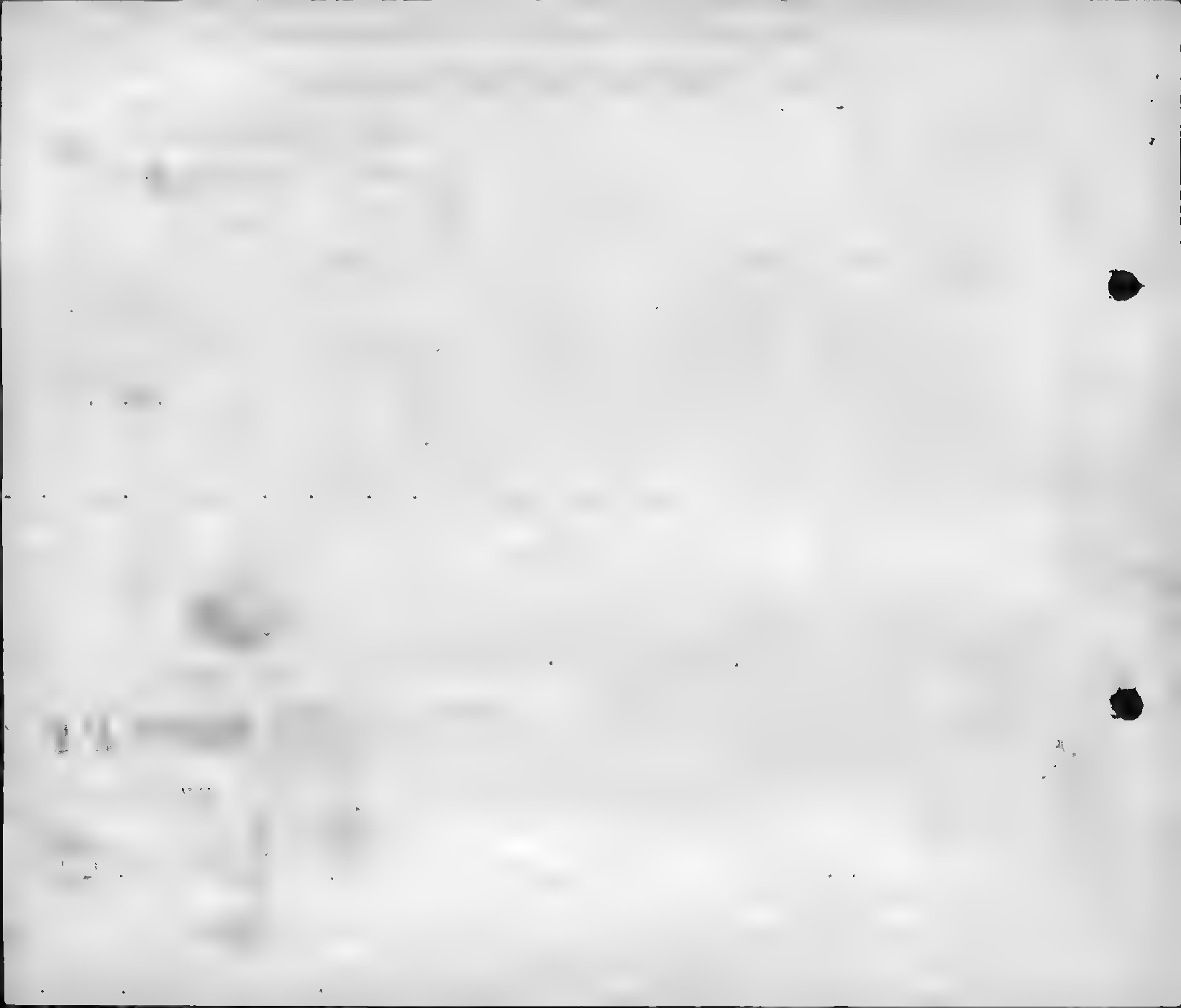
01394

## 1435 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>971 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>321 First Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>LAWRENCE W. COLLISON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 28 1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>September 19, 1899</u>	<b>9. AGE last birthday</b> <u>56</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Handy Man</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Restaurant</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mayo, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>James Collison</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida B. Gardiner</u>			
<b>15. WAS DECEASED EVER IN U S ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>PULMONARY EMPHYSEMA</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>HEALED FIBROCASEOUS TUBERCULOSIS</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____							
DUE TO (C) _____							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>1. COR PULMONALE 2. CIRRHOSIS OF LIVER</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from July 2, 1953, to Feb. 28, 1956, and that death occurred at 9:30 M., from the causes and on the date stated above</b>							
<b>SIGNATURE</b> <u>D. D. MARK, M.D.</u>		<b>ADDRESS</b> (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>					
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3-2-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery Baltimore, Maryland</u>		<b>LOCATION (City, town, or county) (State)</b> <u>2-29-56</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR 5 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm Cook-Blight, Inc.</u>			
<b>DATE</b>		<b>ADDRESS</b>					

Wm. Cook-Blight, Inc., 609 Harford Rd., Balto., Md.



1436

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE				STATE MARYLAND COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD		60 Days		TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 812 E. LOMBARD STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) FRANCIS (Middle) P. (Last) CONNOR				(Month) (Day) (Year) February 10, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	JULY 30, 1893	62 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
STEWARD		STEAMSHIP LINE		BROOKLYN, N. Y.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
PATRICK CONNOR				ANNA KILLIAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
YES WW-1		054-07-1828		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 YEAR (?)	
150X IMMEDIATE CAUSE (A) CARCINOMA ESOPHAGUS							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
12-29-55		GASTROSTOMY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that VA attended the deceased from 12-12-55 to 2-10-56 and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE C. B. COPE, M.D.				ADDRESS (Street, city, town, state) VAH, Fort Howard, Maryland DATE SIGNED 2-12-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		2-15-56		BALTIMORE NATIONAL CEMETERY		BALTIMORE MARYLAND	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE Feb. 14, 1956		Lawson L. Farley		William Cook-Blight Inc. Funeral Home 6009 Harford Rd. Baltimore Md.			

**INSTRUCTIONS**  
 TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
 VS AISC 1-55 10M

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

FEB 15 1936

BUREAU V. S.

1437 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>713 Hillen Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> STREET ADDRESS (If rural give location) <u>713 Hillen Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY MATILDA CROWHART</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>12</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Aug. 20, 1982</u>
9. AGE last birthday: <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Peter Clement Liggett</u>		14. MOTHER'S MAIDEN NAME: <u>Matilda C. Liggett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Robinson Crowhart 713 Hillen Rd. Towson Md</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>414X</u> IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u> ANTECEDENT CAUSE (B) <u>Valvular disease of heart</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Phlebotomy</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>2/12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>2/11/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Denis J. McGrath</u> ADDRESS <u>M.D. 8358 Loch Raven Blvd</u> DATE SIGNED <u>2/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 14, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/12/56</u>		REGISTRAR'S SIGNATURE <u>Denis J. McGrath</u>	
24. FUNERAL DIRECTOR <u>Bernard Hardisty</u>		ADDRESS <u>Salisbury, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1951

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1438 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Ruxton</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Sorrenson Nursing Home</u> <u>7912 Ruxway</u>		<u>1813 East 32nd Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>ALONZA W. CROSS</u>		OF DEATH: <u>Feb. 19</u> , 19 <u>56</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH
<u>male</u>	<u>white</u>	<u>married</u>	<u>Sept. 18, 1882</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	11. CITIZEN OF WHAT COUNTRY?
<u>73</u> yrs		<u>West Virginia</u>	<u>U. S. A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Plasterer</u>		<u>Building Const.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Daniel Cross</u>		<u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>no</u>		17. INFORMANT & ADDRESS:	
		<u>Lyle W. Cross, 4521 Shamrock Avenue</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Myocarditis with failure</u>			<u>5 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>General malnutrition</u>			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	<u>one. treated University Hospital Balto. Md</u>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
<u>no injury</u>	<u>M.</u>	<u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>1956</u> , to <u>1956</u> , that I last saw the deceased <u>alive on</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. H. Manton, M.D.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>burial</u>		<u>Moreland Park Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>2/22/56</u>		<u>Parkville, Maryland</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Herbert W. Cook, Inc.</u>		ADDRESS	
		<u>1217 St. Paul St.</u>	

ARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 442

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balt</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balt</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Arbutus</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1219 Maiden Chica Rd</u>		STREET ADDRESS (If rural, give location) <u>1219 Maiden Chica Lane</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>William S.</u>	(Middle) <u>Cullender</u>	(Last) <u>Levy</u>
4. DATE OF DEATH	(Month) <u>July</u>	(Day) <u>1</u>	(Year) <u>1956</u>
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 8, 1905</u>
9. AGE last birthday: <u>48</u> yrs.		10. MONTHS: <u>4</u>	11. DAYS: <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Sgt</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Br KR</u>	
11. BIRTHPLACE (State or foreign country): <u>Balt</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Cullender</u>		14. MOTHER'S MAIDEN NAME: <u>Mudd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No: <u>713019449</u>	
17. INFORMANT & ADDRESS: <u>Edna M Cullender Maiden Lane</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a).....	DUE TO	<u>Coronary Thrombosis</u>
Antecedent cause(s) (b).....	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Lee Postkammer</u>	1010 Leiden	CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-1-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>2-1-56</u>	NAME OF CEMETERY OR CREMATORY: <u>London Park</u>
LOCATION (City, town, or county) (State): <u>Balt Md</u>	24. FUNERAL DIRECTOR: <u>Howard H. Hubbard</u>	ADDRESS: <u>William Ave</u>
DATE REC'D BY LOCAL REG: <u>July 2 56</u>	REGISTRAR'S SIGNATURE: <u>Lee Postkammer</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01399

## 1439 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Pg.</u>		COUNTY <u>Burkes</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1721 Glen Ridge Rd.</u>				STREET ADDRESS (If rural give location) <u>1338 Mineral Spring Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>George Washington Davis</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Feb. 4, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 1, 1874</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>ret. Retail Clothing</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Penna.</u>	
13. FATHER'S NAME: <u>Franklin Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Emma James</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service): <u>None</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Mrs. W. B. Shoemaker - 1721 Glen Ridge - Towson, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebro vascular accident</u>						3 days	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arterio sclerotic Cardio vascular disease</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>52</u> ; to <u>2/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>56</u> , and that death occurred at <u>5:20</u> P M, from the causes and on the date stated above.							
SIGNATURE <u>Gordon Grant</u>				ADDRESS <u>M. D. 8523 Jock Run Bar</u>		DATE SIGNED <u>2/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Removal</u>		DATE THEREOF: <u>Feb. 7, 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>Miller Funeral Home</u>		LOCATION (City, town, or county) (State): <u>Reading, Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>2/7/56</u>		REGISTRAR'S SIGNATURE: <u>G. M. Bacon</u>		24. FUNERAL DIRECTOR: <u>John Burns' Sons</u>		ADDRESS: <u>Towson, Md.</u>	

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## 1333 CERTIFICATE OF DEATH

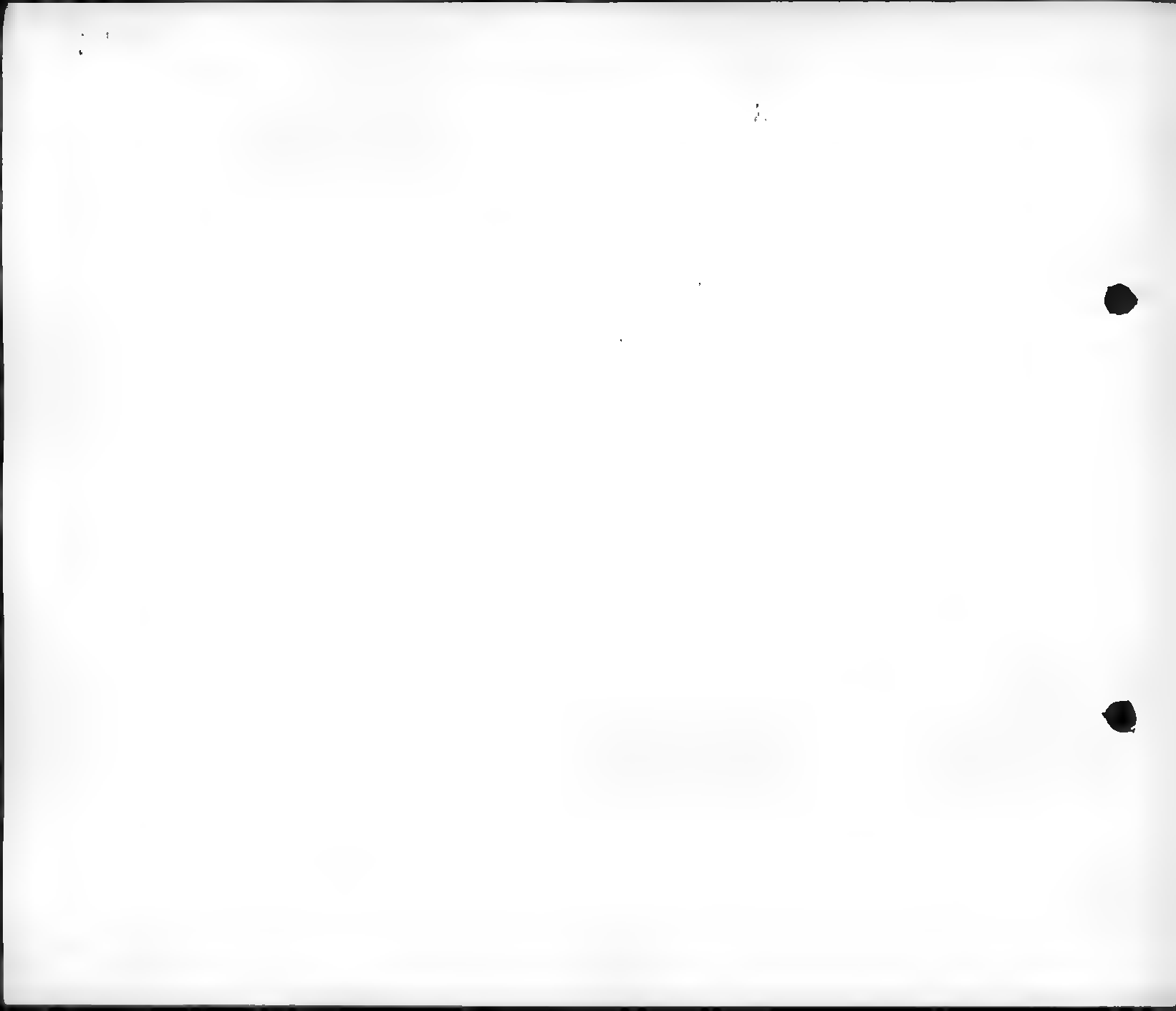
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 TOWN Dundalk</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2914 Dunmurray Road</u>				STREET ADDRESS (If rural give location) <u>2914 Dunmurray Road</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>MELVIN</u> (Last) <u>DAVIS</u>				4. DATE OF DEATH: (Month) <u>Feb.</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 22, 1879</u>	
				9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>George H. Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Adeline Lilly</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Dr. M.B. Davis 6800 Morningson Road. 22</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause				(a) <u>Arterio-Sclerotic-Cardio-Vascular</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.				(b) <u>Renal Disease</u>			
				(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>							
19a. DATE OF OPERATION: <u>Jan 22, 1956</u>				19b. MAJOR FINDINGS OF OPERATION: <u>None</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 22, 1956</u> to <u>Feb 4, 1956</u> that I last saw the deceased alive on <u>Feb 4, 1956</u> and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>McGowan M.S.</u> ADDRESS <u>6800 Morningson Road - Dundalk - 75/56</u> DATE SIGNED <u>Feb 4, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 7, 1956</u>		<u>Trinity Episcopal Church</u>		<u>Churchville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 9, 1956</u>		<u>A. W. Adrich</u>		<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## 1441 CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Balto Co md</u>	<u>Lifa</u>	TOWN <u>Balto Co md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2809 E Joppa Rd</u>		STREET ADDRESS (If rural give location) <u>2809 E Joppa Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
Type or Print: <u>Clarence E Debring</u>		<u>Feb 6 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Dec 7-1877</u>
9. AGE last birthday: <u>78 yrs</u>		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Shopping clerk Koppers Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Balto md</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Anthony Debring</u>		14. MOTHER'S MAIDEN NAME: <u>Regina Klueban spies</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No. <u>215-07-6258</u>	
17. INFORMANT & ADDRESS: <u>Meta Kneafle 2809 E Joppa Rd</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
450.0 IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>			
ANTECEDENT CAUSE (B) <u>and Congestive Failure</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Cachexia &amp; arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Jan 19 55</u> to <u>Feb 6 1956</u> , that I last saw the deceased alive on <u>Feb 6 1956</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frank H. Hankins</u>		DATE SIGNED <u>2/14/56</u>	
M. D. <u>2/14/56</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cen</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-9-56</u>		REGISTRAR'S SIGNATURE <u>Mr. Hammett</u>	
FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

Dr Kasik  
4005 Harvard Rd

BUREAU V. S.

FEB

RECEIVED

1442

01403

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>Md</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Catonsville</b>	LENGTH OF STAY (in this place) <b>1 year</b>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>112 Malbrook Road</b>		STREET ADDRESS (If rural, give location) <b>112 Malbrook Road</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
<b>LILLIAN C. PEICHMÖLLER</b>		<b>FEB 3 1956</b>	
5. SEX: <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married Aug 17, 1899</b>	8. DATE OF BIRTH:
			9. AGE last birthday: <b>56</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Book Binder</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Book Binding</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Bernard J. Connolly</b>		14. MOTHER'S MAIDEN NAME: <b>Rose Short</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <b>2016 36-89587</b>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>William B. Connolly 1605 Shady Side Rd</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause (c) stating underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY)	21c. (City or town)	(County)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Paul F. Kueri</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2-4-56</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>Feb 7-1956</b>	NAME OF CEMETERY OR CREMATORY: <b>Linden Park</b>	
DATE REC'D BY LOCAL REG. <b>2/6/56</b>	REGISTRAR'S SIGNATURE: <b>V.E. Harris</b>	24. FUNERAL DIRECTOR: <b>John F. Seifel</b>	
		ADDRESS: <b>5311 Edmondson Ave</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1443

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>313 Lorraine Ave</u>				d. STREET ADDRESS <u>313 Lorraine Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>E.</u> Last <u>Diggs</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>29th</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8th 1896</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Eva H. Lechter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>311 Lorraine Essex Md.</u> <u>Mrs. Emma Dunham</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular disease</u> DUE TO (c) <u>stroke</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>9 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April, 1947</u> , to <u>Feb 29, 1956</u> , that I last saw the deceased alive on <u>Feb 29, 1956</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.				ADDRESS (Street, city or town, state) <u>423 Eastern Ave</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D. 212nd</u>				DATE SIGNED <u>3/1/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>DATE 5 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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## MEDICAL CERTIFICATION

V5 A15 (4)  
15M 9/55





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01406

1445

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 WINTERS LANE</u>		d. STREET ADDRESS <u>204 WINTERS LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>BRUNER</u> Last <u>DORSEY</u>	4. DATE OF DEATH Month <u>FEB.</u> Day <u>16th</u> Year <u>1956</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/1901</u>
9. AGE (in years last birthday) <u>54 yrs</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (State or foreign country) <u>FREDERICK COUNTY, MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES BRUNER</u>		14. MOTHER'S MAIDEN NAME <u>CLARA NORRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>JOHN L. DORSEY-204 WINTERS LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chromocytoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>5-6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 16, 1955</u> to <u>16 Nov 1956</u> , that I last saw the deceased alive on <u>16 Nov 1956</u> , and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>204 WINTERS LANE, CATONSVILLE, MD.</u> DATE SIGNED <u>Charles R. Davidson</u>			
ACTUAL SIGNATURE <u>Charles R. Davidson</u> M.D. <u>204 WINTERS LANE</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES R. DAVIDSON M.D.</u>		<u>204 WINTERS LANE, CATONSVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/20/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. W. 512 (Annetta Ave)</u>		24. REC'D BY REGISTRAR <u>FEB 20 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

174

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01500

1530

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>		c. LENGTH OF STAY IN 1b <u>13 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco Rural</u>	
3. NAME OF DECEASED (Type or print) <u>SALLIE - M - POSTER</u>		f. STREET ADDRESS <u>1</u>	
4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1956</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 - 1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Touchman</u>		14. MOTHER'S MAIDEN NAME <u>Lydian Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr Earl Greene</u>		Address <u>Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pharynx - metastatic</u> DUE TO 1 - 8 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> to <u>Feb 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M. C. PORTERFIELD, M.D.</u>		DATE SIGNED <u>2/25/56</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stitz</u>		22d. LOCATION (City, town, or county) (State) <u>York Co - Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Darryl B. Elmer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING

may be retained by the hospir

TO FUNERAL DIRECTOR: After the

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOTE: The law requires that the death certificate be executed

attending physician.

certificate has been signed by the attending physician and complete

the burial-transit permit. Then please remove carbon papers.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

24 hours after death. Page 4

filled in by the funeral director,

Pages 1 and 2 should be filed with

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1 55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01407

1446

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bentley Springs</i>		LENGTH OF STAY (in this place) <i>75 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bentley Springs</i>			
TOWN				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>Morgan E. Doster</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Febr. 17, 1956</i>			
<b>5. SEX</b> <i>Male</i>		<b>6. COLOR OR RACE</b> <i>White</i>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> <i>Married</i>		<b>8. DATE OF BIRTH</b> <i>Nov. 7, 1877</i>	
<b>9. AGE</b> (last birthday) <i>78</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS.</b> Hours Min			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Track Foreman Railroad</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Parkton, Md. R.D. G.S.A.</i>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>							
<b>13. FATHER'S NAME</b> <i>Edward Doster</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Miller</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <i>717-07-6721</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs. Bessie Doster, Bentley Springs, Md.</i>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>14. IMMEDIATE CAUSE</b> (A) <i>Acute congestive heart failure</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 day</i>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <i>Diabetes Mellitus</i>							
<b>15. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR COND.T. ON CAUSING DEATH</b> (C)							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>7-30-1955</i> , to <i>2-17-1956</i> , that I last saw the deceased alive on <i>2-17-1956</i> , and that death occurred at <i>9:55 A.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>R. Robinson</i>				<b>ADDRESS</b> (Street, city, town, state) <i>New Freedom, Pa.</i>		<b>DATE SIGNED</b> <i>2-18-56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>Febr. 20, 1956</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Mt. Zion Cemetery, Freeland, Md.</i>		<b>LOCATION</b> (City, town, or county) (State)	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Charles L. Burton</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Jacob Hartenstein</i>		<b>ADDRESS</b> <i>New Freedom, Pa.</i>	
<b>DATE</b> <i>20/2/56</i>							

W. J. P.

FEB 21

REC-10

## 1447 CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MD.</b>	COUNTY <b>BALTIMORE</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>EASTWOOD</b>	LENGTH OF STAY (In this place) <b>6 DAYS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>445 PEMBROOKE BLVD</b>		STREET ADDRESS (If rural give location) <b>121 S. BOULDIN ST.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>MARY ELIZABETH DOULONG</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>Feb., 3, 1956.</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>January 31, 1885</b>
9. AGE last birthday <b>71 yrs</b>		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>House Work</b>	11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md.</b>
13. FATHER'S NAME: <b>JOHN W. MERRYMAN</b>		14. MOTHER'S MAIDEN NAME: <b>CATHERINE STEINMETZ.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Catherine A. Scharpf 445 Pembroke Blvd.</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Arteriosclerosis, C.V. Disease</b>		<b>Spt 11/55</b>	
ANTECEDENT CAUSE (B) <b>Myocardial Failure</b>		<b>Jan 17/56</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>None</b>		19B. MAJOR FINDINGS OF OPERATION: <b>None</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY: <b>None</b>	
21C. WHERE DID INJURY OCCUR: <b>None</b>		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <b>None</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <b>None</b>	
21F. HOW DID INJURY OCCUR? <b>None</b>			
22. I hereby certify that I attended the deceased from <b>Spt 11, 1955</b> , to <b>Feb 3, 1956</b> , that I last saw the deceased alive on <b>Feb 1, 1956</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.			
SIGNATURE: <b>S. G. Schumacher</b>		DATE SIGNED: <b>7-4-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF: <b>2-6-56</b>	
NAME OF CEMETERY OR CREMATORY: <b>DRUID RIDGE CEM.</b>		LOCATION (City, town, or county) (State): <b>PIKESVILLE, MD.</b>	
DATE REC'D BY LOCAL REGISTRAR: <b>Feb 6, 1956</b>		REGISTRAR'S SIGNATURE: <b>C. W. Hedrick</b>	
24. FUNERAL DIRECTOR: <b>Charles S. Giller</b>		ADDRESS: <b>901 S. CONKLING ST. BALTO., MD.</b>	





## 1448 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hoodlawn</u>	STATE <u>Ind</u> COUNTY <u>1</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hoodlawn</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (in this place) <u>16 years</u>	STREET ADDRESS (If rural give location)	<u>6712 Edward Ave</u>
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>C.</u> (Last) <u>DYKE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb</u> <u>11</u> <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>Aug 16/1887</u>
9. AGE last birthday: <u>68</u> yrs.		10. AGE last birthday: <u>68</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Essex, Va Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Dyke</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Edith H. Dyke 6712 Edward Ave</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)	<u>CORONARY THROMBOSIS</u>	<u>1 HR.</u>	
ANTECEDENT CAUSE (B)	<u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>	<u>5 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DEC. 19, 1956</u> , to <u>FEB. 11, 1956</u> , that I last saw the deceased alive on <u>FEB. 11, 1956</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Marrin Goldstein</u>		ADDRESS <u>M. D. 5334 Liberty Heights Ave.</u> DATE SIGNED <u>Feb. 12, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 15/1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		LOCATION (City, town, or county) (State) <u>Hoodlawn Ind</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-18-56</u>		REGISTRAR'S SIGNATURE <u>Harry H. Hunsicker</u>	
24. FUNERAL DIRECTOR <u>Harry H. Hunsicker</u>		ADDRESS <u>4204 Ridgewood Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information—carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1384

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

01411

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltor</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> LENGTH OF STAY (In this place) <u>50 years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1925 Wareham Rd</u>				STREET ADDRESS <u>1925 Wareham Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Helen</u> (First) <u>Dzielinski</u> (Middle) <u>Glass</u> (Last)				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan. 1886</u>	
9. AGE last birthday <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u> ✓	
13. FATHER'S NAME <u>George Konopka</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Skrochi</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-16-8437 B</u>			
17. INFORMANT <u>Mrs. Frances Rice</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Coronary Les.</u>							
Antecedent cause(s) (b) <u>Arterio S. Sclerotic A D</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>21-1-56</u> , 19 <u>56</u> , to <u>1-1-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>21-1-56</u> , 19 <u>56</u> , and that death occurred at <u>1:30 PM</u> m., from <u>Natural</u> causes and on the date stated above.							
SIGNATURE <u>Dr. J. H. Kellum M.D. Dep. Med. Examiner</u>				DATE SIGNED <u>Feb 2 1956</u>			
23. BURIAL, CREMATION OR REMOVAL (Specify)				NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY - ERMAN HILL RD</u>			
DATE REC'D BY LOCAL REG. <u>3-3-56</u>				24. FUNERAL DIRECTOR <u>John M. Weber 4015 Charles St</u>			

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## 1449 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON</u> LENGTH OF STAY (in this place) <u>30 YRS</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 LINDEN TERRACE</u>				STREET ADDRESS (If rural give location) <u>6 Linden Terrace</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>George</u> (Last) <u>Edel</u>				4. DATE OF DEATH: (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>July 25, 1873</u>	
9. AGE last birthday: <u>82</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Accountant</u>		11. BIRTHPLACE (State or foreign country): <u>Balto, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry J Edel</u>				14. MOTHER'S MAIDEN NAME: <u>EVA AMERIN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>NO</u>				16. SOCIAL SECURITY No.: <u>213-05-8766</u>		17. INFORMANT & ADDRESS: <u>Chas H B Edel (son) 6 Linden Terr Towson 4, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Coronary occlusion</u>							
Antecedent causes (s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Pleurisy</u>							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input type="checkbox"/>				Interval Between Onset and Death <u>12 hours</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>				PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 30</u> , 19 <u>56</u> , to <u>Feb 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>56</u> , and that death occurred at <u>8:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A. J. Chalfont</u> (Degree or title)				ADDRESS <u>6210 York Rd Baltimore 4</u> DATE SIGNED <u>Feb 16, 56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>None</u>				DATE THEREOF <u>Feb 18 1956</u> NAME OF CEMETERY OR CREMATOR <u>Green Mount</u> LOCATION (City, town, or county) (State) <u>Balto Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Feb 18 1956</u>				REGISTRAR'S SIGNATURE <u>Don</u> 24. FUNERAL DIRECTOR <u>W. H. ...</u> ADDRESS <u>4905 York Rd</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form is especially important. Physicians: please write the causes of death clearly and legibly.



## 1450 CERTIFICATE OF DEATH

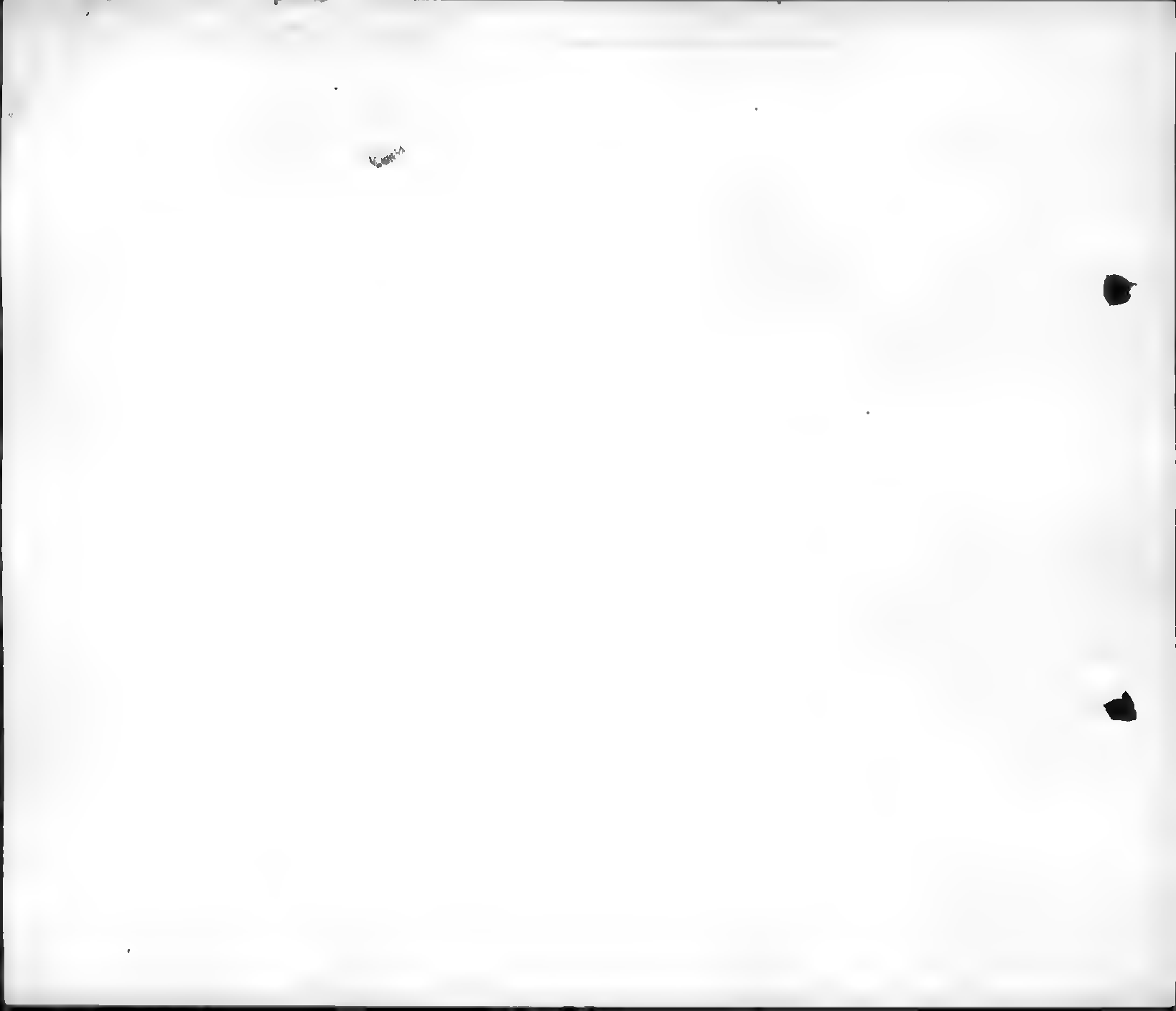
Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1530 John Street</u>	
3. NAME OF DECEASED. (First) (Middle) (Last) <u>Mae Belle Elliott</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 5, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>12-13-1887</u>
9. AGE last birthday <u>68</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Demonstrator</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Vinton F. Merryman</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Diffenbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Rupture of heart</u>			
ANTECEDENT CAUSE (B) <u>Subacute myocardial infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Coronary arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bilateral Pyonephrosis</u>			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-1-1953</u> , to <u>2-5-1956</u> , that I last saw the deceased alive on <u>2-5-1956</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Stella Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u> <u>M. D. Catonsville 28, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Westminster, Md.</u>		LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 7, 1956</u>		REGISTRAR'S SIGNATURE <u>G. L. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons - Balt. 17 Ind.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## 1451 CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>137 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>5062 Orville Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Type or Print: <u>MELVIN C EMMEL</u>				OF DEATH <u>February 25 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH: <u>12/12/13</u>	
9. AGE last birthday: <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life): <u>Refrigeration Mechanic</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>August C. Emmel</u>				14. MOTHER'S MAIDEN NAME: <u>Helen O'Hara</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WWII</u>				16. SOCIAL SECURITY No. <u>216-07-2498</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vets. Admin. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA WITH CEREBELLAR METASTASIS</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 11, 1955</u> , to <u>February 25, 1956</u> , that I last saw the deceased <u>and that death occurred at 11:45 AM, from the causes and on the date stated above.</u>							
SIGNATURE <u>A. G. EDWARDS, M.D.</u>				ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>		DATE SIGNED <u>2/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 28, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Schimmey Funeral Home</u>		ADDRESS <u>2601 E. Madison Ave., Balto., Md.</u>	

MARGIN RESERVED FOR BINDING



1452 **CERTIFICATE OF DEATH**

Reg. Dist. No. 35

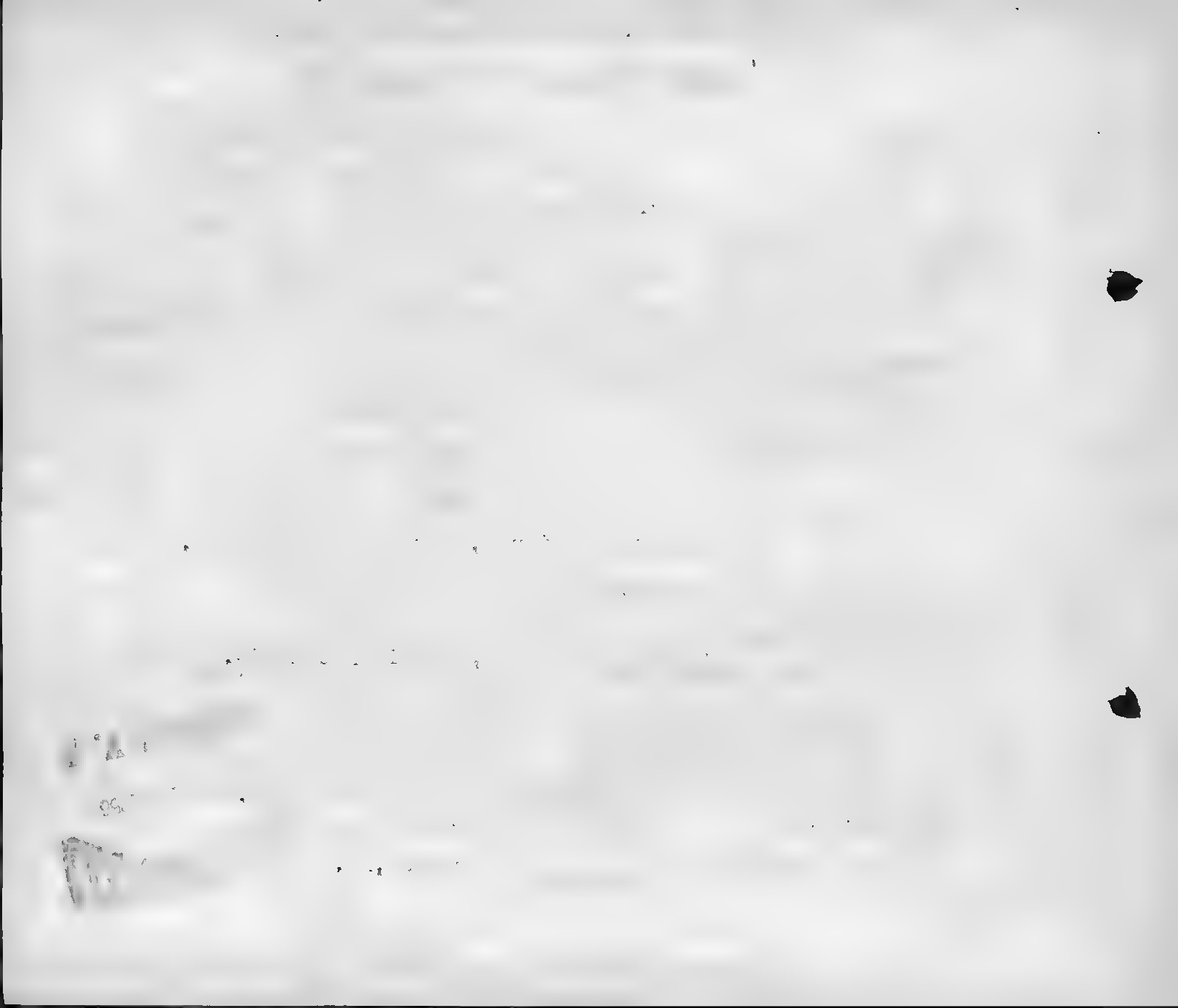
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Parkton</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd.</u>				STREET ADDRESS (If rural give location) <u>Falls Rd.</u>			
<b>3. NAME OF</b> (First) (Middle) (Last) <u>Clifton Tansley Ensor</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2 8 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>Feb 22 1873</u>	
9. AGE last birthday <u>80</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm whet</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Luke E Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Laura Tansley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Edward Harry Ensor Parkton Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cardiac Failure, Pulmonary Hypostasis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Senility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>Chronic Nephritis, Chronic Prostatitis.</u>							
STATING UNDERLYING CAUSE LAST, DUE TO TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Feb 6, 1956</u> <b>to</b> <u>Feb 8, 1956.</u> <b>that I last saw the deceased</b> <u>alive on Feb 8, 1956</u> <b>and that death occurred at</b> <u>12 noon</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>J. Lee Brooks</u> <b>M.D.</b> <u>New Freedom, Pa.</u> <b>DATE SIGNED</b> <u>Feb 8, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Black Rock Cem</u>		LOCATION (City, town, or county) (State) <u>Butler Md.</u>	
24. REC'D BY REGISTRAR <u>DATE 2-11-56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Howard S. Mathews</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lee Brooks, Sparks, Md.</u>			

VS AISC 1-55 10M

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801416  
1453 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Catonsville</b>		LENGTH OF STAY (in this place) <b>2yrs. 7mth. 29days.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>Mechanicsville, Md.</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <b>Della</b>		(Middle)		(Last) <b>Ferrell</b>		(Date) <b>Feb. 28 19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widow</b>	8. DATE OF BIRTH: <b>Oct. 1, ?</b>	9. AGE last birthday <b>85</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>--</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>John Herbert</b>				14. MOTHER'S MAIDEN NAME: <b>Rebecca</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT & ADDRESS: <b>Records of Spring Grove State Hospital</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <b>Cardiac failure with myocardial involvement</b>					
ANTECEDENT CAUSE (B)		DUE TO <b>Arteriosclerotic cardiovascular disease</b>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-30, 1955</b> , to <b>2-28, 1956</b> , that I last saw the deceased alive on <b>2-28, 1956</b> , and that death occurred at <b>5:03pm</b> , from the causes and on the date stated above.							
SIGNATURE <b>Gaula W. A. ...</b>		ADDRESS <b>SPRING GROVE STATE HOSP. Catonsville 28, Md.</b>		DATE SIGNED <b>2-28-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3-2-56</b>		NAME OF CEMETERY OR CREMATORY <b>St John's</b>		LOCATION (City, town, or county) (State) <b>Clinton, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>3/5/56</b>		REGISTRAR'S SIGNATURE <b>E. ...</b>		24. FUNERAL DIRECTOR <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 81

1956

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1454

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 32

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Mount Airy</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Smith Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>CHARLES</u> (Middle) <u>EDWARD</u> (Last) <u>FIDLER</u>		4. DATE OF DEATH (Month) <u>FEBRUARY</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>August 7 1941</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>14</u> yrs. Months <u>14</u> Days <u>14</u> Hours <u>14</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Edward Fidler</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Anna Stacker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>See</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Charles E. Fidler, Jr. Smith Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Inhalation of Fire &amp; Generalized</u>	Antecedent cause(s) (b) <u>Complete Body Burns Entire</u>	
(c) <u>Clathing on Fire Death by Suffocation</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

1. EXTERNAL CAUSE WAS PRIMARY* OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) (Sec)	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>In trying to start a fire in iron coal stove in kitchen which exploded, setting fire to kitchen.</u>			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.					
SIGNATURE <u>Edna Fidler</u>		ADDRESS <u>7501 York Rd. Towson 4</u>		DATE SIGNED <u>Feb 5, 1956</u>	
DATE RECEIVED BY LOCAL REG. <u>Feb 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Frank H. Newell</u>		24. FUNERAL DIRECTOR <u>William H. Newell</u>	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 7 1950

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly

1455 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01418

Item 21 Film 6193 2-24-56 ans

Medical Examiner

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fullerton</u>				TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 494 Fitch Ave.</u>				STREET ADDRESS (If rural give location) <u>Box 494 Fitch Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>William F. Fitch</u>				DEATH: <u>Feb. 9 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>July 19, 1892</u>	9. AGE last birthday: <u>63</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Truck Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Fitch</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Hoeb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs. Elizabeth Hefner-7723 Belair Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized Abdominal Cramping</u>						1 minute	
ANTECEDENT CAUSE (B) <u>injury - Accidental Death</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Rear of home</u>		21C. WHERE DID (City or town) (County) (State) <u>Fullerton Balto. Md.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>inspected on 2-10-56</u>		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>tractor he was driving on beneath driver's seat into ditch and it overturned on top</u>			
22. I hereby certify that I attended the deceased from <u>2-10-56</u> to <u>2-11-56</u> , that I last saw the deceased alive on <u>2-11-56</u> and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jack Collins M.D. Deputy Medical Examiner</u>		ADDRESS <u>2401 Belair Rd.</u>		DATE SIGNED <u>2-14-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-13-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 11-1956</u>		REGISTRAR'S SIGNATURE <u>Dr. J. B. Perkins</u>		24. FUNERAL DIRECTOR <u>Carroll Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

RECEIVED

FEB 16 1956

BUREAU V. S.

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01419

## 1456 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>STENARD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>PARKVILLE</u>		<u>4 DAYS</u>		TOWN <u>PARKVILLE</u> (14)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3022 WILLOUGHBY RD.</u>				STREET ADDRESS (If rural give location) <u>STENARD STATION, PA.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOUIS</u> (Middle) <u>HENRY</u> (Last) <u>FITZELL</u>				(Month) <u>7</u> (Day) <u>10</u> (Year) <u>1956</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>17 JUNE 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCK FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS R. FITZELL</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA LOHMULLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>AL</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-22-8505</u>		17. INFORMANT'S ADDRESS <u>L. MORGAN FITZELL - SEE #1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>cerebral Hemorrhage.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.		M.					
22. I hereby certify that I attended the deceased from <u>2-9</u> , 19 <u>56</u> , to <u>2-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>56</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold H. B. Wins</u> M.D. <u>8106 Harford Rd.</u>				DATE SIGNED <u>2-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>CHURCH LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
24. REC'D BY REGISTRAR <u>FEB 1 - 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Ruth Bradley, Norfolk, VA.</u>		ADDRESS	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. A third copy of this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01420

## 1457 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>		LENGTH OF STAY (In this place) <u>3 mos</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2719 Maple Ave</u>				STREET ADDRESS (If rural give location) <u>3801 W. Harrison Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>William D. Fleagle</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 19 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>M</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Aug 24 1889</u>	9. AGE last birthday <u>66</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>	
13. FATHER'S NAME <u>Thos H. Fleagle</u>				14. MOTHER'S MAIDEN NAME <u>Martina O. Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>218-05-9035</u>		17. INFORMANT & ADDRESS <u>Mrs Terwin Lewis 2719 Maple Ave</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
a. IMMEDIATE CAUSE (A) <u>Bronchogenic carcinoma with</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several mos.</u>	
b. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>generalized metastases</u>							
c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>				21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Feb 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>56</u> , and that death occurred at <u>11:38 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William D. Fleagle</u>				ADDRESS (Street, city, town, state) <u>8100 Harford Rd. Balto. 18 Md.</u>		DATE SIGNED <u>2-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR <u>Dr. A. M. Brown</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>5005 W. Highland Balto 15 Md</u>	



## 1458 CERTIFICATE OF DEATH

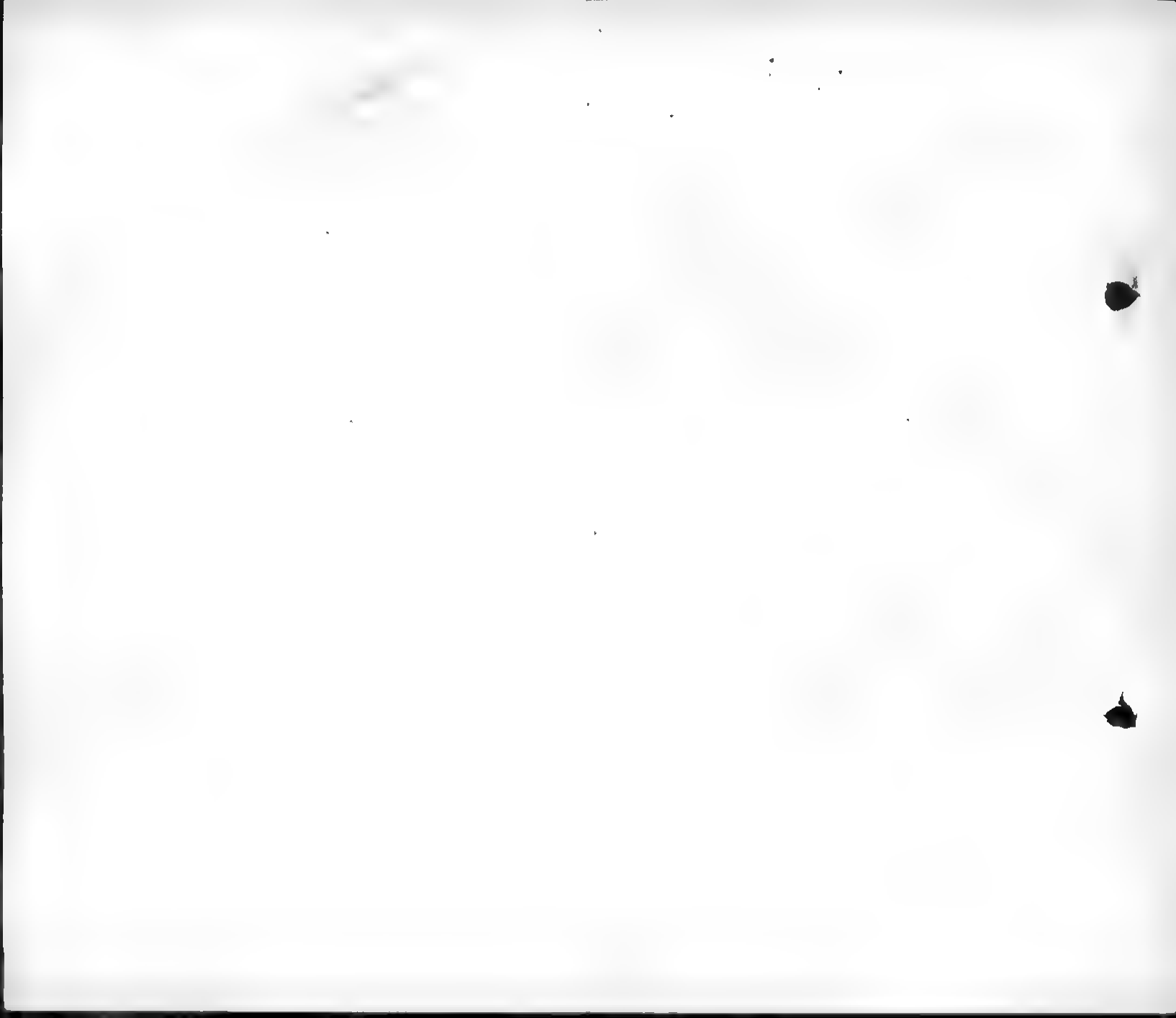
Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>2621 N. Calvert Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lillian F. Foard</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 14, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-1879</u>
9. AGE last birthday <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John B. Gallaher</u>		14. MOTHER'S MAIDEN NAME: <u>Julia E. McAdee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>7-</u> , 19 <u>53</u> to <u>2-14-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-14-</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stella Woodrider</u>		DATE SIGNED <u>2-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2/17/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 15, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1459

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>1 Day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>4335 Falls Road</u>	
3. NAME OF DECEASED. (Type or Print) <u>HARRY JAMES FRANK</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 24 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3/16/92</u>
9. AGE last birthday: <u>63</u> yrs		10. MONTHS <u>24</u> DAYS <u>24</u> HOURS <u>00</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Senior Investigator B&amp;O Railroad</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Elias Theodore Frank</u>		14. MOTHER'S MAIDEN NAME: <u>Welthy A.A. Thayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>705-09-1127</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN
IMMEDIATE CAUSE (A) <u>CARCINOMA OF PROSTATE WITH METASTASIS</u>		
DUE TO <u>TO RIBS AND VERTEBRA</u>		
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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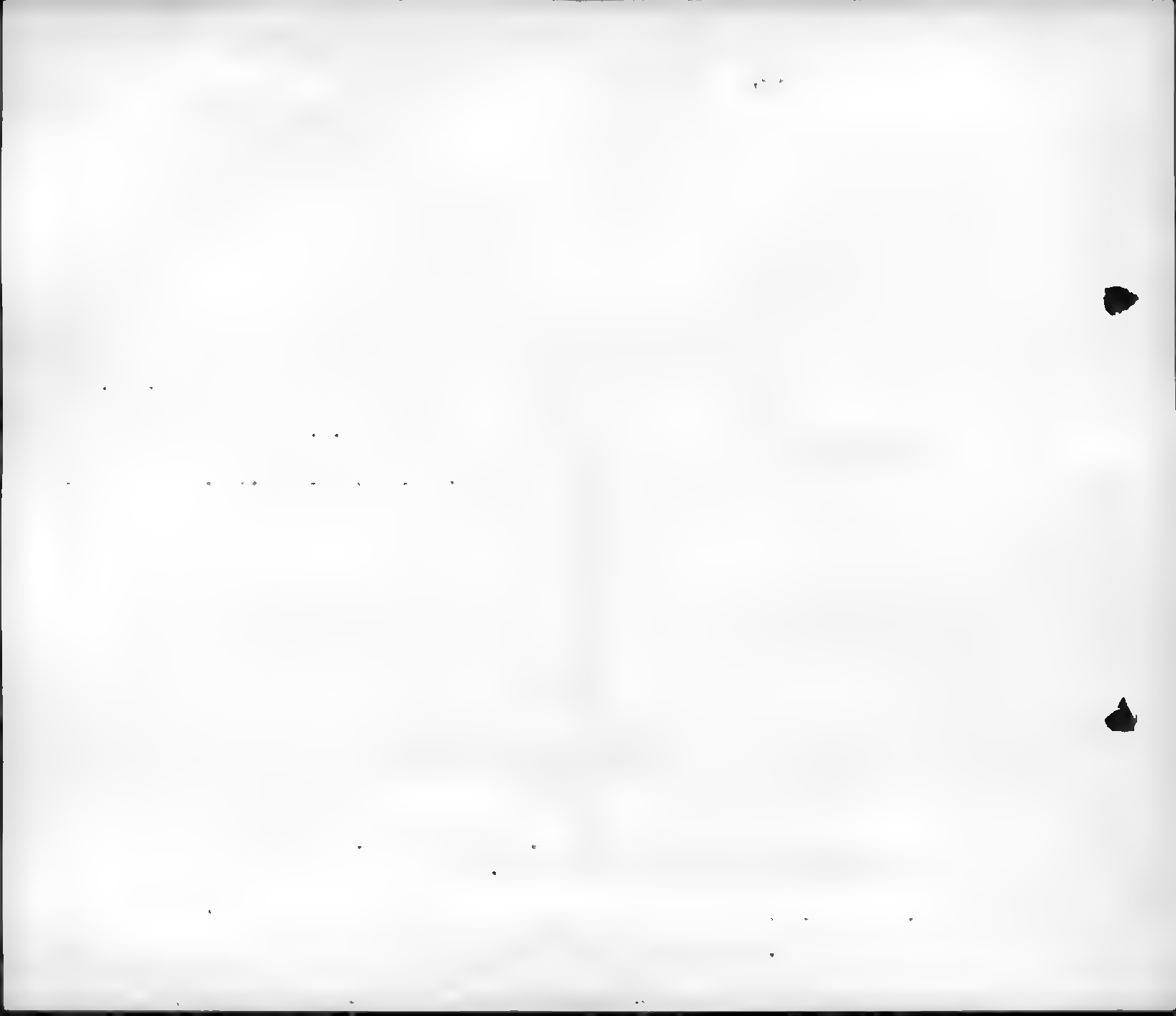
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1956, to Feb. 24, 1956, and that death occurred at 11:20 M. from the causes and on the date stated above.	
SIGNATURE <u>Donald D. Mark M.D.</u>	DATE SIGNED <u>Feb. 28, 1956</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Feb. 28, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>2/27/56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>	ADDRESS <u>3631 Falls Rd. Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01423

1460

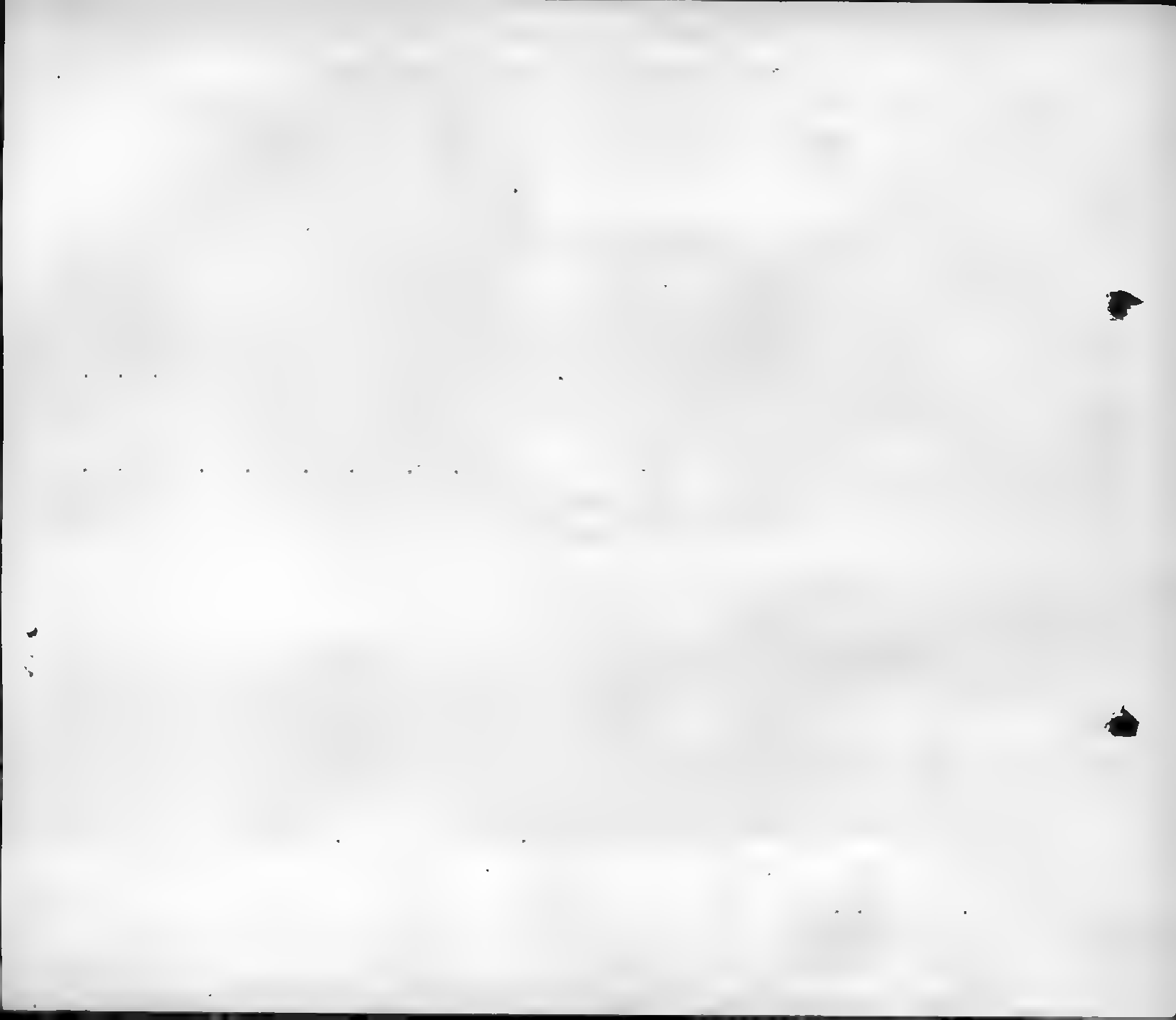
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Fort Howard</u>	<u>6 Hours 30M.</u>	OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>3608 Mary Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>LAWRENCE J. FRANKEL</u>		<u>February 29 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED. <u>Widowed</u>	8. DATE OF BIRTH <u>February 19, 1887</u>
9. AGE last birthday <u>69</u> yrs.   Months   Days   Hours   Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hat Blocker</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Rudolph Frankel</u>		14. MOTHER'S MAIDEN NAME: <u>Julia Nohe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>214-03-0888</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA</u>		<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Min.)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 29, 1956, to Feb. 29, 1956, and that death occurred at 6:20 M. from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Jerome Cvach Funeral Home, 900 N. Chester St. Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply very item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN - R HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01424

## 1461 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>8 Days</u>		TOWN <u>5535 Windsor Mill Road, Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>5535 Windsor Mill Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>FRANK F. FULENWIDER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 28 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 29, 1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Payroll Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Henrietta, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Fulenwider</u>				14. MOTHER'S MAIDEN NAME <u>Clara Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-12-1369</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
X IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA, RIGHT LUNG AND MEDIASTINUM</u>						UNKNOWN	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 20</u> , 19 <u>56</u> , to <u>Feb. 28</u> , 19 <u>56</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>2-28-56</u>	
23. BURIAL, CREMATON, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>MAR 5 1956</u>		<u>Wm. Cook-Blight, Inc.</u>		<u>6009 Harford Rd. Balto. Md.</u>			

1. A. 1000000

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1462 CERTIFICATE OF DEATH

01425

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>7 yrs.</u>		TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Balto County Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Gibson</u> (Last)				(Month) <u>Feb</u> (Day) <u>11</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Feb 11 1900?</u>	<u>66?</u> yrs	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Levi Benton</u>				<u>Nancy T. ...</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>B. H. Co. Home R. ...</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						<u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>						<u>5-70. s.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1940</u> to <u>Feb 1956</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth B. ...</u> M.D. <u>Cockeysville Md.</u>				DATE SIGNED <u>2/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>2/11/56</u>		<u>Mount Airy ...</u>		<u>... Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2/11/56</u>		<u>...</u>		<u>...</u>		<u>...</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)  
9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

## CERTIFICATE OF DEATH

01426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe, Md.</b>				c. LENGTH OF STAY IN 1b <b>30</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5704 First Ave.</b>				d STREET ADDRESS <b>5704 First Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Gillis</b> Last <b>Gillis</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1880</b>	
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coppers Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Gilbert Gillis</b>				14. MOTHER'S MAIDEN NAME <b>Jane Campe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212-09-8546</b>			
17. INFORMANT <b>George W. Gillis</b>				Address <b>5601 Ashbourne Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Retention of prostate gland</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Retention of prostate - E. capsule removed</b> (c) <b>Prostatitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>470 F</b> <b>6 mos</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore</b>				20g. (County) <b>Baltimore</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>1926</b> , to <b>Jan 23, 1956</b> , that I last saw the deceased alive on <b>Feb 23rd, 1956</b> , and that death occurred at <b>12:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frederick V. Doster</b>				M.D. <b>1014 Fremont Ave - Baltimore - 7-9456</b>			
PHYSICIAN'S NAME (Type) <b>Howard H. Hubbard</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 27, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>				ADDRESS <b>4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR <b>Feb 27 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. S. Sheffer</b>							

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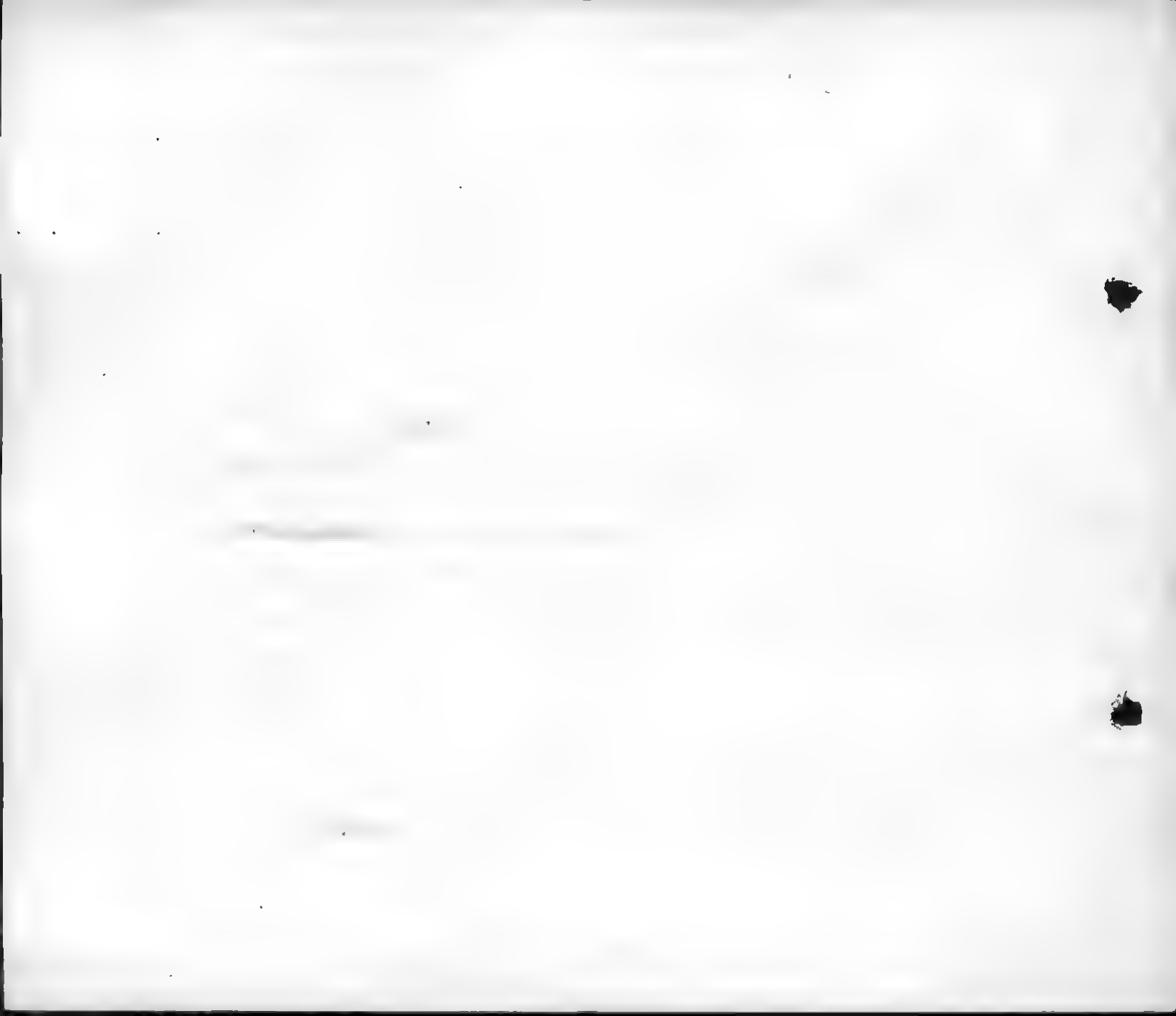
## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Balto. City</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Catonsville</b>		LENGTH OF STAY (In this place) <b>3yrs. 8mths. 27days.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>730 N. Kenwood Ave. - Balto. 5.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Anna Handy Gosnell</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Feb. 28, 1956</b>			
5. SEX: <b>female</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>		8. DATE OF BIRTH: <b>March 9, 1886</b>	
9. AGE last birthday <b>69</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>seamstress</b>		10a. KIND OF BUSINESS OR INDUSTRY: <b>unknown</b>		9. AGE last birthday IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11. BIRTHPLACE (State or foreign country): <b>Maryland, Baltimore</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME: <b>Charles E. Handy</b>				14. MOTHER'S MAIDEN NAME: <b>Maggie Eiman Handy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT & ADDRESS: <b>Records of Spring Grove State Hospital</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Hypertensive cardiovascular disease</b>							
ANTECEDENT CAUSE (B) <b>Arteriosclerotic cardiovascular disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <b>Cardiac hypertrophy due to overstrain</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Cardiac dilitation due to overstrain</b>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July</b> , 1953 to <b>Feb. 28</b> 1956, that I last saw the deceased alive on <b>Feb. 28, 1956</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Suea Wachler</b>		M. D. <b>SPRING GROVE STATE HOSP: Catonsville 28, Md.</b>		DATE SIGNED <b>2-28-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Mar. 3, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2601-3-5 E. Madison St.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01428

1464

## CERTIFICATE OF DEATH

Reg. Dist. No. 428

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		LENGTH OF STAY (in this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Old York Rd</i>				STREET ADDRESS (If rural give location) <i>Old York Rd.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Maddalena Lintz Graef</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>2-13-1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>8-8-1878</i>	
9. AGE last birthday <i>77</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Lintz</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Waltz</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>				16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT & ADDRESS <i>Frederic E. Graef, Phoenix, Md.</i>	
<b>18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>19. MEDICAL CERTIFICATION</b>			
170X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				170X IMMEDIATE CAUSE (A) <i>Carcinoma of Breast</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Coronary Arteriosclerosis</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb-14-1956</i> to <i>Feb-14-1956</i> that I last saw the deceased alive on <i>Feb-14-1956</i> , and that death occurred at <i>5:10 P.M.</i> from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-16-56</i>		NAME OF CEMETERY OR CREMATORY <i>Evangelical Reform</i>		LOCATION (City, town, or county) (State) <i>Hawthorne, Balto. Co. Md.</i>	
24. REC'D BY REGISTRAR DATE <i>Feb-15-56</i>		REGISTRAR'S SIGNATURE <i>V. W. Timm</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Scott Brooks</i>		ADDRESS <i>Sparks, Md.</i>	
26. SIGNATURE OF DECEASED <i>Elizabeth Gorskuch</i>							

FEB 1

1950

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

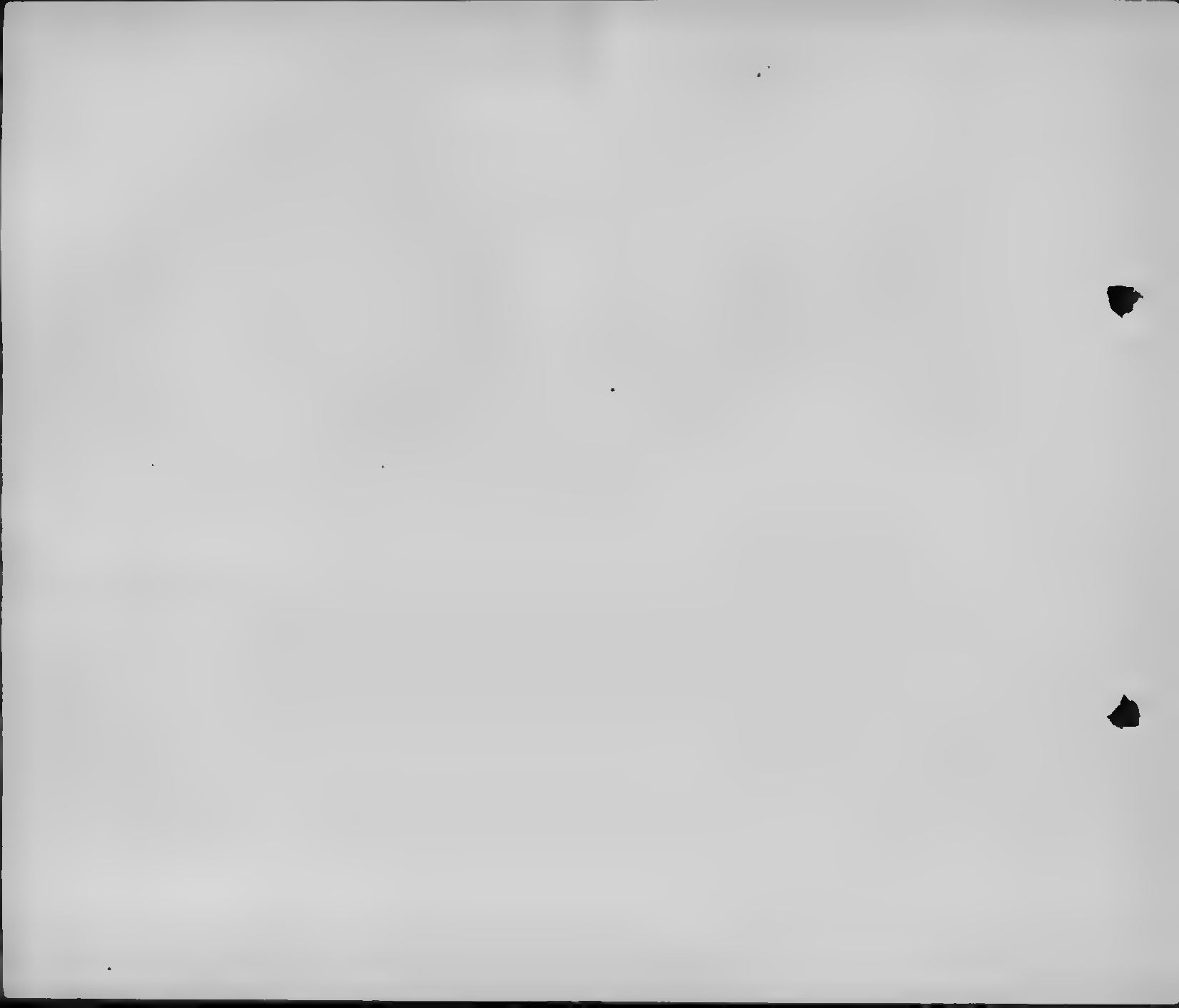
Reg. Dist. No. ....

1465

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Black &amp; Decker Co. - Jopp Rd.</u>		STREET ADDRESS (If rural, give location) <u>1909 W. North Avenue</u>	
3. NAME OF DECEASED (Type or Print) First (Middle) (Last) <u>FRANK L GRANGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 17 1956</u>	
5. SEX <u>M</u>	6. COLOR <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/21/1895</u>
9. AGE last birthday <u>60</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Dover, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Windolph</u>		14. MOTHER'S MAIDEN NAME <u>Eva C. Granger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No	
17. INFORMANT AND ADDRESS <u>Margaret G. Valentine 1909 W. North Ave.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4 - Immediate cause (a) <u>Coronary Thrombosis</u></u> <u>Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u></u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy Inspection & Inquiry thereon and from the evidence obtained by and Autopsy, Inspection or Inquiry, find that he died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE (Degree or title)		ADDRESS	
DATE OF EXAMINATION (Month) (Day) (Year) <u>2/22/56</u>		LOCATION (City, town, or county) (State) <u>Dover, Delaware</u>	
DATE RECEIVED BY LOCAL HEALTH OFFICIAL (Month) (Day) (Year) <u>Feb 22, 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law 802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

USE WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





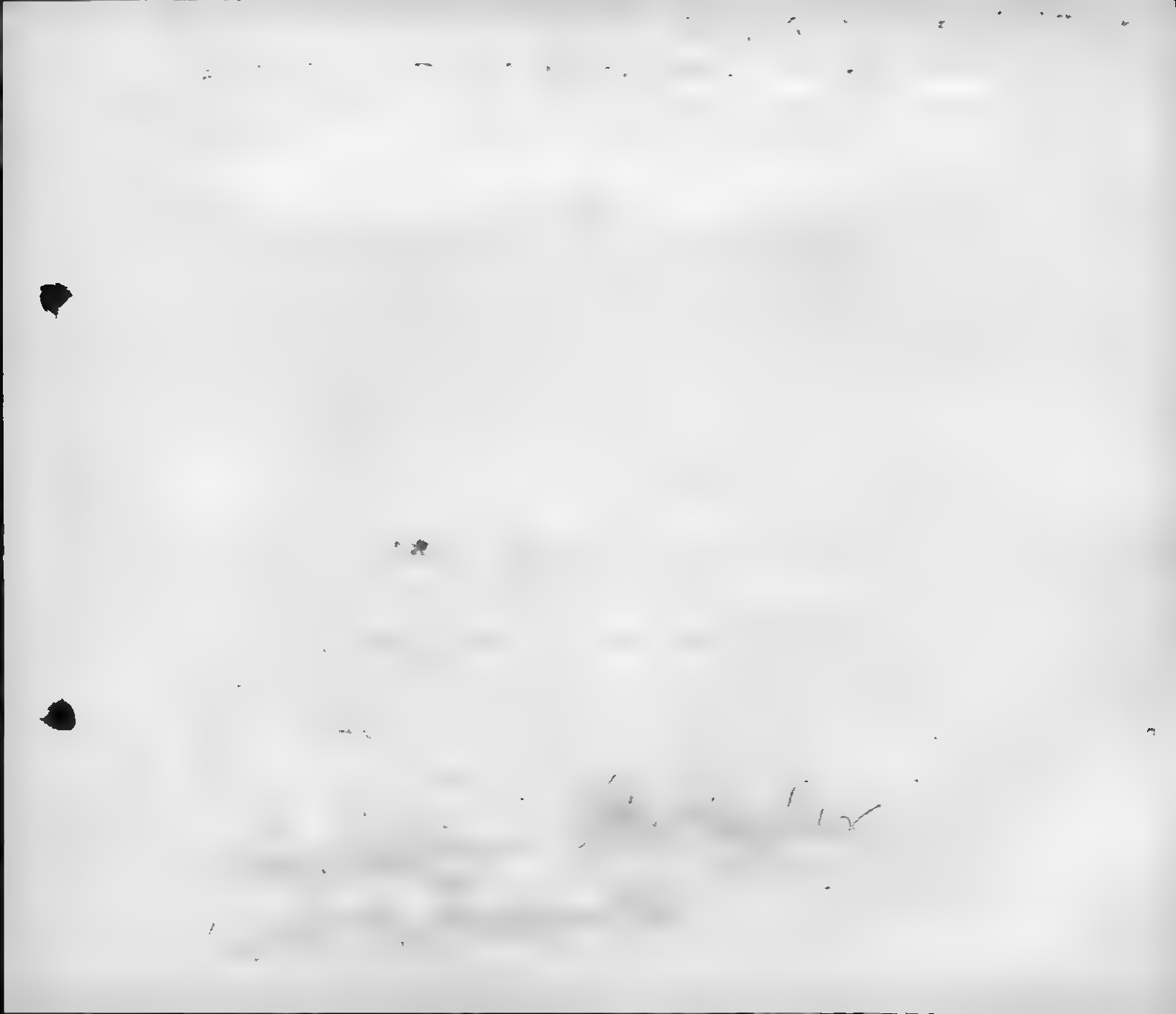
## 1466 CERTIFICATE OF DEATH

Reg. Dist. No. 3c

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>5 WKS.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOUSE IN THE PINES NURSING HOME.</u>		STATE <u>MD.</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (if rural give location) <u>1012 S. ELLWOOD AVE.</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JOHN HERMAN GRESS</u>		OF DEATH <u>FEB. 16, 1956.</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAY 13, 1876</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>79</u> yrs		<u>BALTIMORE, MD.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>BALTIMORE, MD.</u>		<u>UNKNOWN</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>? GRESS.</u>		<u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO.</u>		<u>NONE</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Broncho-Pneumonia</u> ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Chronic Hypertensive Cardio-Vascular Disease</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-20, 1956</u> , to <u>2-16, 1956</u> , that I last saw the deceased alive on <u>2-16, 1956</u> , and that death occurred at <u>2:47 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William K. Gallagher</u>		ADDRESS <u>M.D. Catonsville-28, Md.</u> DATE SIGNED <u>2-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>BURIAL</u>		<u>2-20-56</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>SACRED HEART CEM.</u>		<u>7401 GERMAN HILL RD., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
		<u>Charles S. Duler</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Charles S. Duler</u>		<u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.



1467

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>SARRETT</u>		STATE <u>MARYLAND</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>MT WILSON</u>		LENGTH OF STAY (in this place) <u>3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		OR TOWN <u>OAKLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT. WILSON ST. Hospital</u>				STREET ADDRESS (If rural give location) <u>RD #2 Box 309</u>			
3. NAME OF DECEASED: (First) <u>ALICE</u> (Middle) <u>ALICE</u> (Last) <u>GRIFFITH</u>				4. DATE (Month) (Day) (Year) OF DEATH. <u>2</u> <u>19</u> <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH <u>10.22.1884</u>	
9. AGE last birthday <u>71</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Wayville, W. VA.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Clifford Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Clolly Good</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT & ADDRESS:							

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Far advanced pulmonary tuberculosis</u>		DUE TO			
ANTECEDENT CAUSE (B) <u>Diabetes</u>		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>2008</u>		(C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					

19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Nov. 8, 1955, to Feb. 19, 1956, that I last saw the deceased alive on Feb. 19, 1956, and that death occurred at 11 A.M., from the causes and on the date stated above.

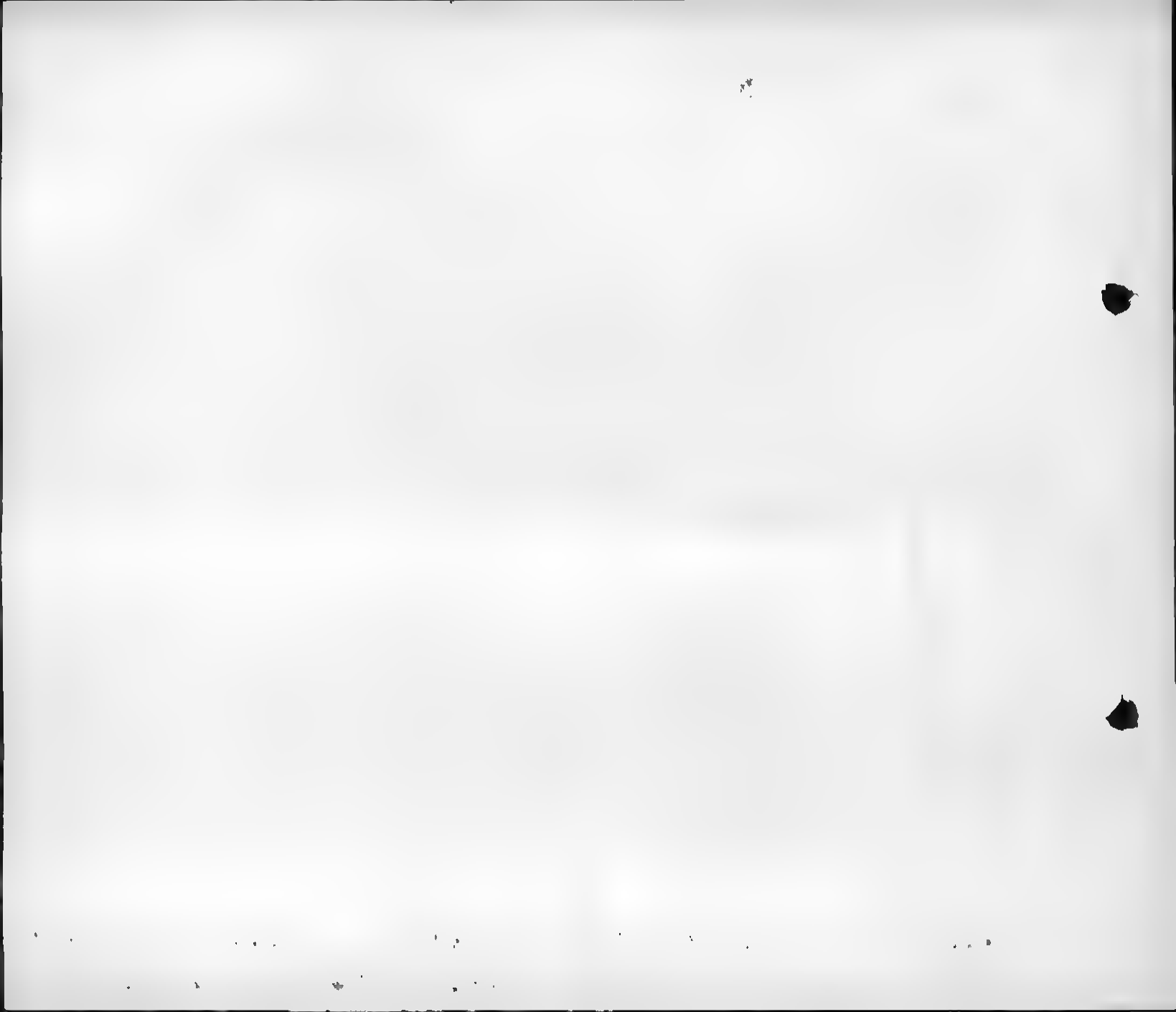
SIGNATURE <u>William Newman</u>		ADDRESS <u>MT. WILSON STATE Hosp.</u>		DATE SIGNED <u>Feb. 17, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>FEB. 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>GNEGY CHURCH CEM.</u>	
LOCATION (City, town, or county) <u>GARRETT CO. Md.</u>					

DATE REC'D BY LOCAL REGISTRAR <u>FEB 26, 1956</u>	REGISTRAR'S SIGNATURE <u>W. V. Hedrick</u>	24. FUNERAL DIRECTOR <u>William Cook, Jr.</u>	ADDRESS <u>1217 St. Paul St.</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01432

## 1468 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> STREET ADDRESS (If rural give location) <u>County Home</u>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last) <u>Sally</u> <u>Franklin</u> <u>Hall</u> (Type or Print)			<b>4. DATE (Month) (Day) (Year) OF DEATH:</b> <u>February 23,</u> 19 <u>56</u>				
<b>5. SEX:</b> <u>Female</u>	<b>6. COLOR OR RACE:</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>Widowed</u>	<b>8. DATE OF BIRTH:</b> <u>10-1-1879</u>	<b>9. AGE last birthday</b> <u>76</u> yrs.	<b>IF UNDER 1 YEAR, Months Days Hours Min.</b> IF UNDER 24 HRS.		
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):</b> <u>Unknown</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY:</b> <u>Unknown</u>		<b>11. BIRTHPLACE (State or foreign country):</b> <u>Maryland</u>			
<b>13. FATHER'S NAME:</b> <u>R. T. Connor</u>			<b>14. MOTHER'S MAIDEN NAME:</b> <u>Elizabeth Franklin</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)</b> <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Records Spring Grove State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u> ANTECEDENT CAUSE (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>		
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19A. DATE OF OPERATION:</b>		<b>19B. MAJOR FINDINGS OF OPERATION</b>					
<b>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?</b>			
<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work</b>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>8-23-</u>, 19 <u>55</u> to <u>2-23-</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>2-23-</u>, 19 <u>56</u>, and that death occurred at <u>10:45A</u>, from the causes and on the date stated above.</b> SIGNATURE <u>G. Wachler</u> M. D. ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>2-23-56</u>							
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Entombed in Wood</u>		<b>DATE THEREOF</b> <u>2-24-56</u>		<b>NAME OF CEMETERY</b> <u>Univ. of Md. Med. School</u>			
<b>DATE REC'D BY LOCAL REGISTRAR</b> <u>1-5-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>24. FUNERAL DIRECTOR ADDRESS</b> <u>Baltimore, Md.</u>			

BRITISH Y. L.

FEB 20

1944

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01433

1385

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u> MD.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>225 MAPLE AVE</u>		STREET ADDRESS (If rural, give location) <u>225 MAPLE AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WOODIE</u>	(Middle) <u>ROBERT</u>	(Last) <u>HALL.</u>
4. DATE OF DEATH	(Month) <u>2</u>	(Day) <u>4</u>	(Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-26-1896</u>
9. AGE last birthday <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAN</u>	
11. BIRTHPLACE (State or foreign country) <u>ALBEMARLE COUNTY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HALL</u>		14. MOTHER'S MAIDEN NAME <u>PEARL WOOD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>218-10-6505</u>	
17. INFORMANT AND ADDRESS <u>PEARL HALL 225 MAPLE AVE. 22</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) --

Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

6 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) --

Arteriosclerotic Heart Disease

4 yrs

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 1, 1955, to Feb 4, 1956, that I last saw the deceased

alive on Feb 4, 1956, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE

E. R. Evans

(Degree or title)

ADDRESS

1 Liberty Parkway

DATE SIGNED

Feb 4, 1956

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	<u>2-7-1956</u>	<u>PRIZE HILL CEMETERY VA</u>	<u>BUONESVILLE</u>	<u>VIRGINIA</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb 5 - 1956</u>	<u>Wm. E. Kelley</u>	<u>Walter Roberts</u>	<u>1100 S. 1st St. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

RECEIVED

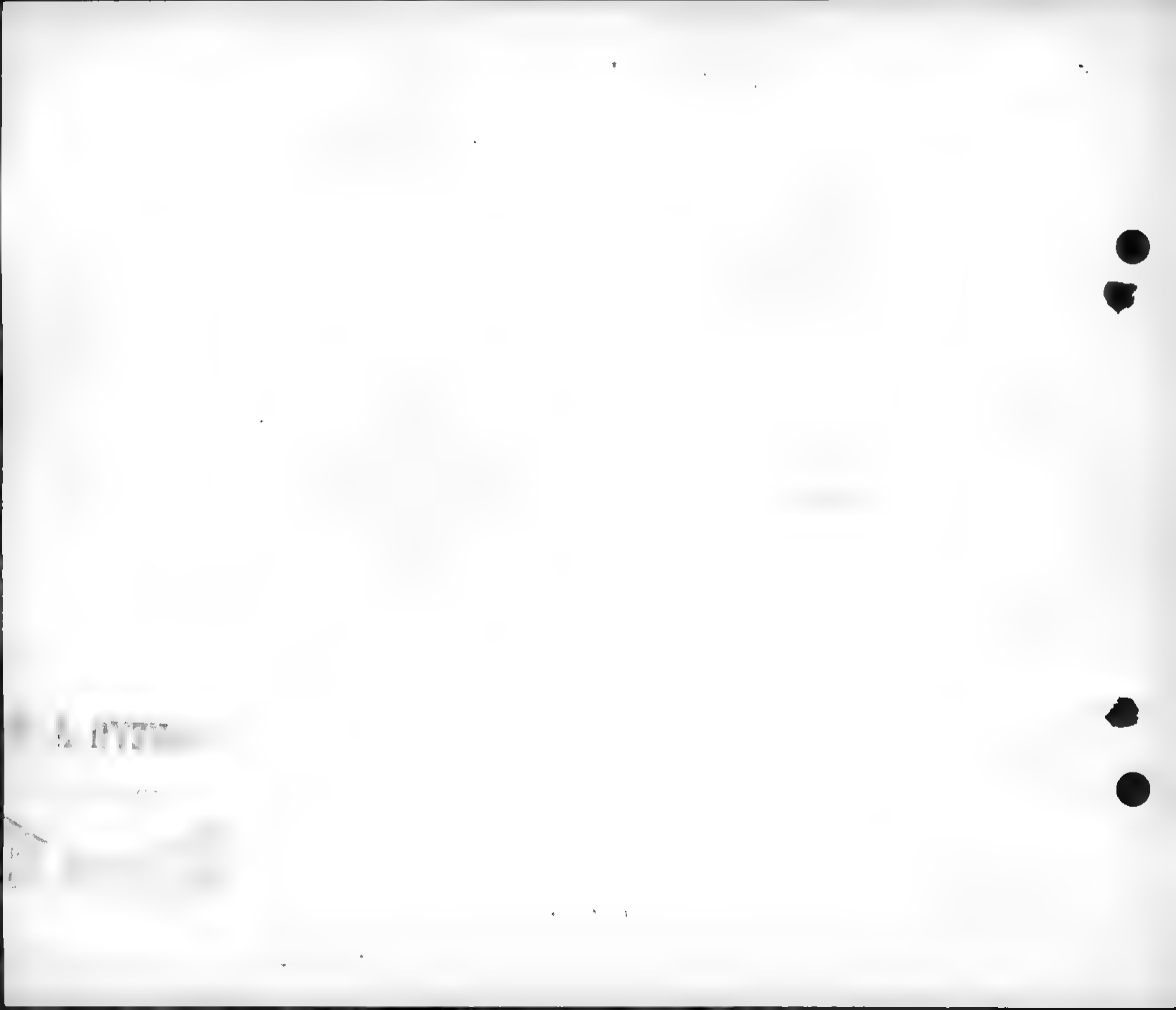


## 1469 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i> 19		STATE <i>MD</i> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <i>in</i> X	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural, give location)	
X <i>Spawcross Pt.</i>		<i>63 yrs.</i>		<i># 1.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<i>710 E. St.</i>					
3. NAME OF DECEASED: (Type or Print)		(First) <i>ANTON</i>		(Middle) <i>A.</i>		(Last) <i>HALVORSEN</i>	
6. SEX: <i>male</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>		8. DATE OF BIRTH: <i>Jan 10. 1862</i>		9. AGE last birthday: <i>94</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rigger</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Steel mill</i>		11. BIRTHPLACE (State or foreign country): <i>Norway</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Unknown</i>		14. MOTHER'S MAIDEN NAME: <i>Unknown</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>212-16.5655</i>	
				17. INFORMANT & ADDRESS: <i>address as in # 1.</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
443X Immediate cause (a) <i>Cerebral Hemorrhage + hemiplegia</i>				<i>2 days ago</i>			
Antecedent cause(s) (b) <i>Hypertensive cardiovascular disease</i>				<i>20 yrs.</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <i>atherosclerosis</i>				<i>20 yrs.</i>			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.				<i>prior Cerebral hemorrhage + hemiplegia 18 mo.</i>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 22, 1955</i> to <i>Feb. 7, 1956</i> , that I last saw the deceased alive on <i>Feb. 7, 1956</i> , and that death occurred at <i>8:30 P.m.</i> , from the causes and on the date stated above.		SIGNATURE <i>Dawson D. Lark</i>		(DEGREE OR TITLE) ADDRESS <i>6908 North Pt. Rd. Balto. 19-md.</i>		DATE SIGNED <i>2/7/56</i>	
23. BURIAL CREMATION (Specify): <i>BURIAL</i>		DATE THEREOF <i>2-10-56</i>		NAME OF CEMETERY OR CREMATORY <i>MORELAND MEM. PARK</i>		LOCATION (City, town, or county) (State) <i>BALTO. CO., MD.</i>	
DATE REC'D BY LOCAL REG. <i>Feb. 9/1956</i>		REGISTRAR'S SIGNATURE <i>Dawson D. Lark</i>		24. FUNERAL DIRECTOR <i>Walt. Burke Brady, Dundalk, Md.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1470

## CERTIFICATE OF DEATH

Reg. Dist. No.

01435

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>2mths. 21 dys.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRINGGROVE STATE HOSP.</u>		STREET ADDRESS (If rural give location) <u>9131 Avondale Rd. - Parkville 14, Md.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lillie A Hamilton</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 9, 1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>1-29-1898</u>
9. AGE last birthday <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John A. HANCOCK</u>		14. MOTHER'S MAIDEN NAME: <u>ANNA ELISA GORDEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Records of Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>Hypertensive arteriosclerotic heart disease</u>			
(B) ANTECEDENT CAUSE (S) <u>General arteriosclerosis, hypertension</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Diabetes, obesity</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>July, 1953</u> to <u>Feb. 9, 1956</u> that I last saw the deceased alive on <u>Feb. 9, 1956</u> and that death occurred at <u>12:00 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>L. Wayne Williams</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>Maryland Memorial</u>	
DATE THEREOF <u>2-11-56</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 10, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Evans + Son 5502 Harbor Rd.</u>	



01436

## MARYLAND STATE DEPARTMENT OF HEALTH

1471 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overleg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overleg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 Councilman Ave</u>		STREET ADDRESS (if rural, give location) <u>5 Councilman Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Martha</u>	(Middle) <u>H.</u>	(Last) <u>Hanson</u>
4. DATE OF DEATH	(Month) <u>Feb</u>	(Day) <u>16</u>	(Year) <u>1956</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 6 1890</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>16</u> If under 24 hrs. Hours <u>16</u> Mins. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Menomonie Wis.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Klatt</u>		14. MOTHER'S MAIDEN NAME <u>Henneretta ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Herbert A. Hanson 5 Councilman</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

31X

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

5 hrs.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 19. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☒

## 21. EXTERNAL CAUSE WAS

PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☒ suicide ☒ homicide ☒ undetermined ☒

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Jack Challen Dist. Med. Ex. Balt 222-16-56

23. RIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG

REGISTRAR'S SIGNATURE

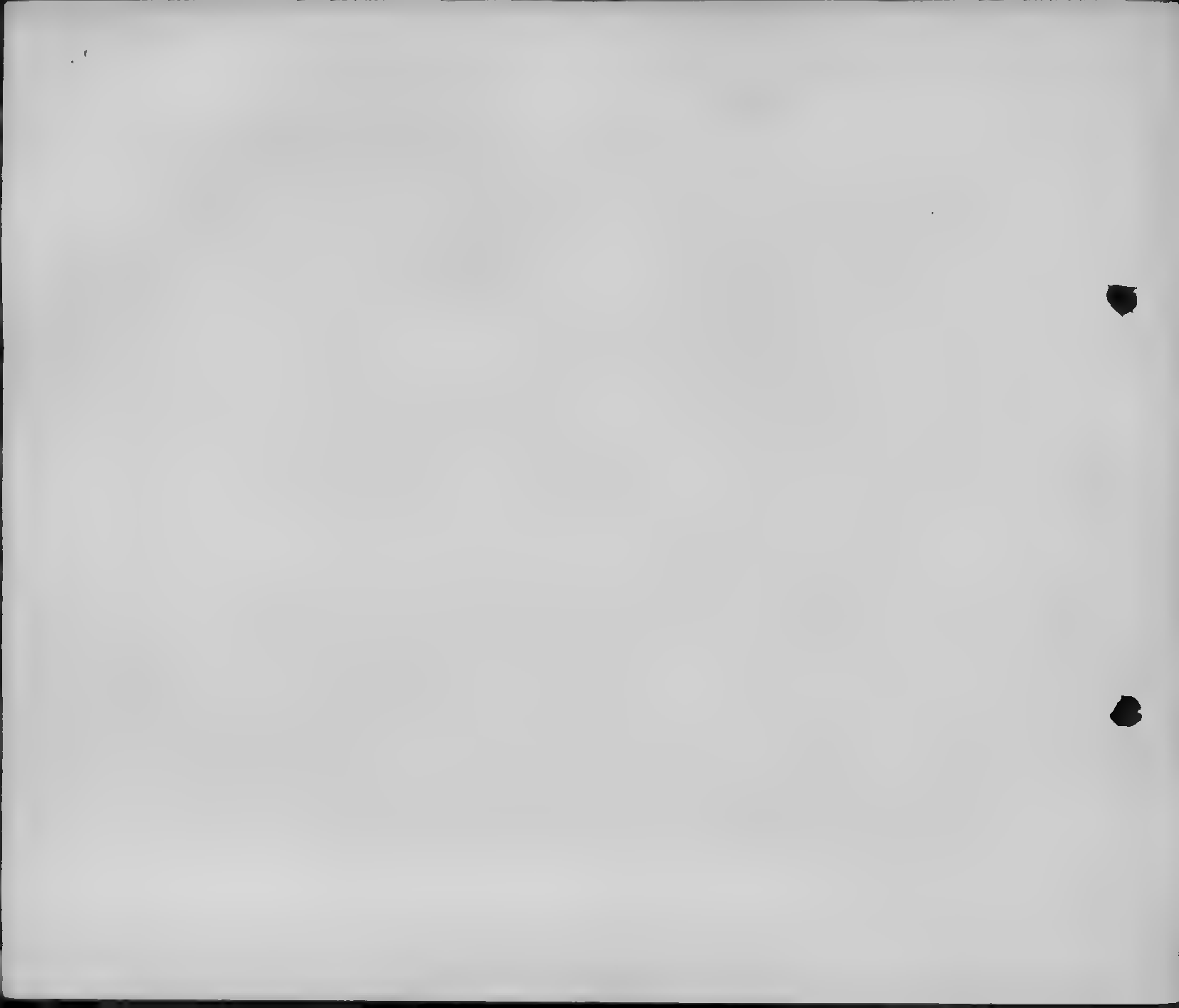
24. FUNERAL DIRECTOR

ADDRESS

Feb - 16, 195666Herbert A. Hanson110 BELAIR RD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



## 1472 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY _____		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u> 15 days			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>			STREET ADDRESS (If rural give location) <u>7236 Sollers Point Road</u>		
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM (NM) HARPER</u>			4. DATE (Month) (Day) (Year) OF DEATH <u>February 10 19 56</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11/3/98</u>		9. AGE last birthday <u>57</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinist</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Machine Shop</u>		11. BIRTHPLACE (State or foreign country): <u>Everson, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME: <u>John E. Harper</u>		
14. MOTHER'S MAIDEN NAME: <u>Mary O'Donahue</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>Yes WWI</u>		
16. SOCIAL SECURITY NO.: <u>218-28-0739</u>			17. INFORMANT & ADDRESS: <u>Clin. Red., Vet. Adm. Hosp., Ft. Howard, Md.</u>		

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	<u>ARTERIOSCLEROTIC HEART DISEASE</u>	<u>UNKNOWN</u>
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 26 1956, to February 10 1956, that I last saw the deceased alive on <u>February 10 1956</u> , and that death occurred at 9:05 PM, from the causes and on the date stated above.			
SIGNATURE <u>John J. Kennedy</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>2/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2-14-56</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE RECD BY LOCAL REGISTRAR <u>Feb. 14, 1956</u>	REGISTRAR'S SIGNATURE <u>Dawson L. Larkins</u>	ADDRESS <u>John Brooks Bradley Funeral Home, Inc. 700 Willow Spring Rd., Balto. 22, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 16 1950  
BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1473

## CERTIFICATE OF DEATH

01438

Reg. Dist. No. 39

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Monkton</u>		LENGTH OF STAY (in this place) <u>8 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			
TOWN				STREET ADDRESS (If rural give location) <u>Monkton Rd</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monkton Rd</u>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Grayson</u> <u>Harris</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 24</u> <u>1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Sept 22 1883</u>	<b>9. AGE last birthday</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland - Balto Co Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George Henry Harris</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Cromwell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Wife - Estelle Harris</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardio-vascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>over 8 1/2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from February 19 <u>18</u> to February 19 <u>56</u>, that I last saw the deceased alive on <u>24 Feb</u>, 19 <u>56</u>, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Walter T. Keas</u>				<b>DATE SIGNED</b> <u>February 24 1956</u>			
<b>23. BURIAL, CREMATON, REMOVAL (Specify)</b> <u>Burial</u>				<b>DATE THEREOF</b> <u>Feb 25-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Colored</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR</u>				<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Eliza G. Gorchuck</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Marion Sking Jancos</u>	
<b>DATE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>ADDRESS</b>	
				<u>Cocheyville Md</u>		<u>24 Feb. 1956</u>	
				<u>Forest Hill, Md</u>			

2 4 0 7

MAR 2

RECEIVED  
MAR 2 1971

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**1474 FOR MEDICAL EXAMINERS**

01439

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oliver Beach</u> TOWN <u>Oliver Beach</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oliver Beach</u> TOWN <u>Oliver Beach</u> STREET ADDRESS <u>Rt. 14 Box 112</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>BOWEN</u> (Last) <u>HAUF</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>3-16-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Albert Hauf</u>		14. MOTHER'S MAIDEN NAME <u>Welen Bower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Florence Hauf (Same)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Arteriosclerosis

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or office bldg., etc.) Home  
INJURY No

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY? Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY 2 21 56 11 PM

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED 2/28/56

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 2-21-56

NAME OF CEMETERY OR CREMATORY Balto. National

LOCATION (City, town, or county) Balto.

(State) Md.

DATE REC'D BY LOCAL REG. Feb 20, 1956

REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR John J. Connelley

ADDRESS Essex Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1475 CERTIFICATE OF DEATH

01440

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>8117 Bon Air Road</b>				STREET ADDRESS (If rural give location) <b>8117 Bon Air Road</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mrs. Ada Violet Heberling</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>February 15, 1956</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>June 10, 1880</b>		<b>9. AGE last birthday</b> <b>75 yrs.</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.) <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Clearfield County, Penna</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John Smith</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Jennie</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Thelma Gail Brungard, 8117 Bon Air</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A)				<b>Myocarditis c. degeneration</b>		<b>6 Mos.</b>	
ANTECEDENT CAUSE(S) DUE TO (B)				<b>Coronary Thrombosis</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<b>Arteriosclerosis</b>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Aug. 1955, to Feb. 1956, that I last saw the deceased alive on Feb. 14, 1956, and that death occurred at 9:10 P.M. from the causes and on the date stated above.</b> <b>SIGNATURE</b> <b>Frank D. Karik</b> <b>M.D.</b> <b>9005 Harford Rd</b> <b>DATE SIGNED</b> <b>2/16/56</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb. 18, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Hill Crest Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Clearfield, Penna.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Paul M. Beck</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

100-1000

83

100-1000

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

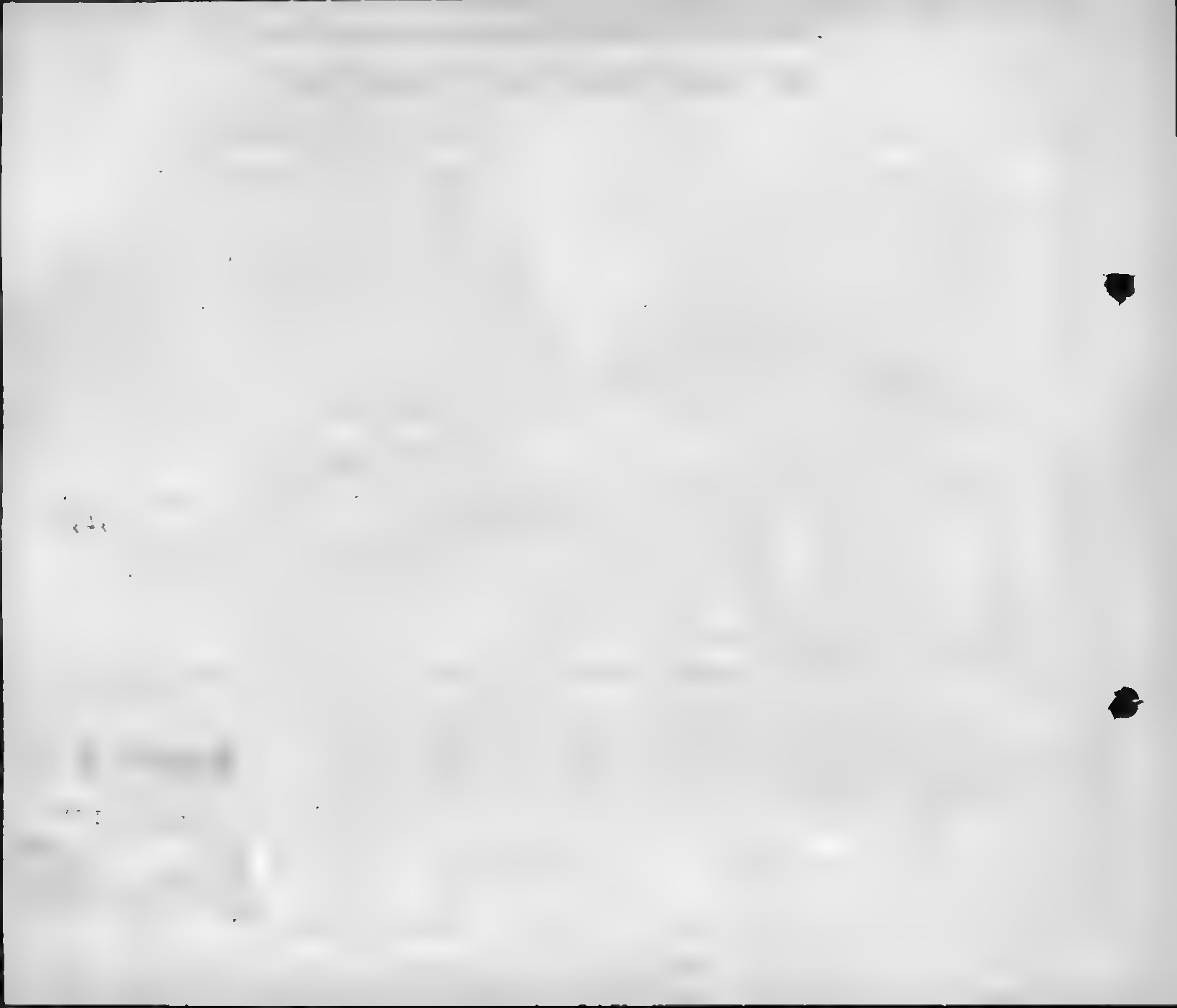
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1476 CERTIFICATE OF DEATH

01442

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Balto.		MARYLAND		STATE		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Payson Ave.				STREET ADDRESS (If rural give location) 4 Payson Ave.			
3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) F. (Last) Hefner				4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1956			
5. SEX	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH July 24, 1887	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Ret		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Hefner				14. MOTHER'S MAIDEN NAME Lena Ste r			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS J. J. ... on Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET OF DEATH 4 yrs.			
IMMEDIATE CAUSE (A) Coronary Thrombosis Arterio-sclerotic cordis - base disease							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 18, 1956, to Feb. 21, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE George H. Yeager				ADDRESS (Street, city, town, state) Med. ext Bldg. Balto (1) Md. DATE SIGNED Feb. 23, 1956			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF 2-24-56		NAME OF CEMETERY OR CREMATORY St. John's		LOCATION (City, town, or county) (State) Balto. Md.	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE T. E. Barry		25. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md.			





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801443

Items 8, 9, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1477

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWSON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>610 Marwood Road</u>		STREET ADDRESS (If rural give location) <u>610 Marwood Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ELIZABETH SWIRES HENRY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 17, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 19, 1910</u>
9. AGE last birthday: <u>44</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Joseph Swires</u>	
14. MOTHER'S MAIDEN NAME: <u>Bertha Ellen Craft</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Maynard Henry, 610 Marwood Rd., Towson, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) <u>CEREBRAL HEMORRHAGE</u>			<u>1 hr</u>
IMMEDIATE CAUSE DUE TO			
(B) <u>HYPERTENSION</u>			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>FEB 17, 1956</u> to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>FEB 17, 1956</u> , and that death occurred at <u>10:50 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edward L. Zupnik</u>		ADDRESS <u>M.D. 427 Hopkins Rd.</u>	
DATE SIGNED <u>2/19/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 21, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Phillipsburg Cemetery</u>		LOCATION (City, town, or county) (State) <u>Phillipsburg, Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 20, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
24. FUNERAL DIRECTOR <u>John Burns Sons</u>		ADDRESS <u>Towson, Maryland</u>	

100000 V. S.

23

100000 V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01444

1478

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home, 8001 Duvall Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS <u>8001 Duvall Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>BERTHA</u> (First) <u>FRIEDA</u> (Middle) <u>HERBERT</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>25</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 10-1880</u>
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Spath</u>		14. MOTHER'S MAIDEN NAME <u>Winkler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Clarence E. 8001 Duvall Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Carcinomatosis</u>		<u>1 year</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Carcinoma of Breast</u>		<u>2 years</u>	
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>10-6-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of breast</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9-17-52</u> , 19....., to <u>2-25-56</u> , 19....., that I last saw the deceased alive on <u>2-25-56</u> , 19....., and that death occurred at <u>2:10 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James R. Mumm</u>		ADDRESS <u>8019 Philadelphia Rd. Balt. 6, Md.</u>	
DATE SIGNED <u>2-25-56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-29-56</u>	NAME OF CEMETERY OR CREMATORY <u>Green Lake Cem</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE REC'D BY LOCAL REG. <u>Mar. 26</u>	REGISTRAR'S SIGNATURE <u>James R. Mumm</u>	24. FUNERAL DIRECTOR <u>Wendell Lassalle Funeral Home 7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-2  
80'

U.S. AIR FORCE

18 JUL 1950

RECEIVED

## 1386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>1421 MAXWELL AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>S</u> Middle <u>HERMAN</u> Last		4. DATE OF DEATH <u>FEB</u> Month <u>27</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 12 1895</u>
9. AGE (in years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILL WRIGHT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL PLANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AUGUST L. HERMAN</u>		14. MOTHER'S MAIDEN NAME <u>MAHIE OEHM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>HEINRY L. HERMAN 25N STEEPLER ST</u>	
17. INFORMANT <u>HEINRY L. HERMAN</u>		Address <u>25N STEEPLER ST</u>	
17b. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M B Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 1-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Crailock Funeral Home DUNDALK</u>		24a. REC'D BY REGISTRAR <u>Mar. 1, 1956</u>	
ADDRESS <u>2112</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley M. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAR 5

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01446

1479

## CERTIFICATE OF DEATH

Reg. Dist. No.

20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN		<u>2 days</u>		<u>PASADENA, MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Spring Grove Hosp.</u>				<u>MAGOTHY BEACH</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>RAYMOND GRADY HICKS</u>				<u>FEB 12 1956</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>M</u>	<u>W</u>	<u>WIDOWED July</u>	<u>1980</u>	<u>75</u> yrs			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Fisherman</u>				<u>Self Employed</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Benjamin Hicks</u>				<u>Alice Grady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Mary Samn, Cecil Rd., Millersville, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)							
<u>Hypertensive cardiovascular disease</u>							
ANTECEDENT CAUSE (B)							
<u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> 19 <u>56</u> , to <u>2/12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/12</u> , 19 <u>56</u> , and that death occurred at <u>145 P</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Norman E. Shapiro, MD</u>		<u>Spring Grove Hosp.</u>		<u>2/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 15, 1956</u>		<u>Cedar Hill Cem.</u>		<u>Brooklyn, T.P.D., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 15, 1956</u>		<u>John E. Barry</u>		<u>Funeral Home of J. Barry</u>		<u>not</u>	

BUKENDU N. K.

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## 1480 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>1.</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonville</u>				TOWN <u>Catonville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10 <u>Paradise Nursing Home</u>				16 <u>Lunmore Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Robert</u> (Middle) <u>S.</u> (Last) <u>Hilbrecht</u>				(Month) <u>5</u> (Day) <u>19</u> (Year) <u>50</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
			<u>July 31, 1974</u>	<u>21</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Iron Mt. Steel Co.</u>		<u>Steel Co.</u>		<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Hilbrecht</u>				<u>---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. Robert Hilbrecht 16 Dunmore</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Myocardial failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Arteriosclerotic CVD</u>				<u>6 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Benign prostatic hypertrophy</u>				<u>3 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-27</u> , 19 <u>50</u> , to <u>2-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-4</u> , 19 <u>56</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Stephen Lee Magness</u>				<u>M.D. 908 Frederick Rd. Catonsville</u>		<u>2-7-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>2-3-56</u>				<u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
		<u>T. E. Hanyo</u>		<u>Early Funeral Home - Catonsville, Md.</u>			
DATE							

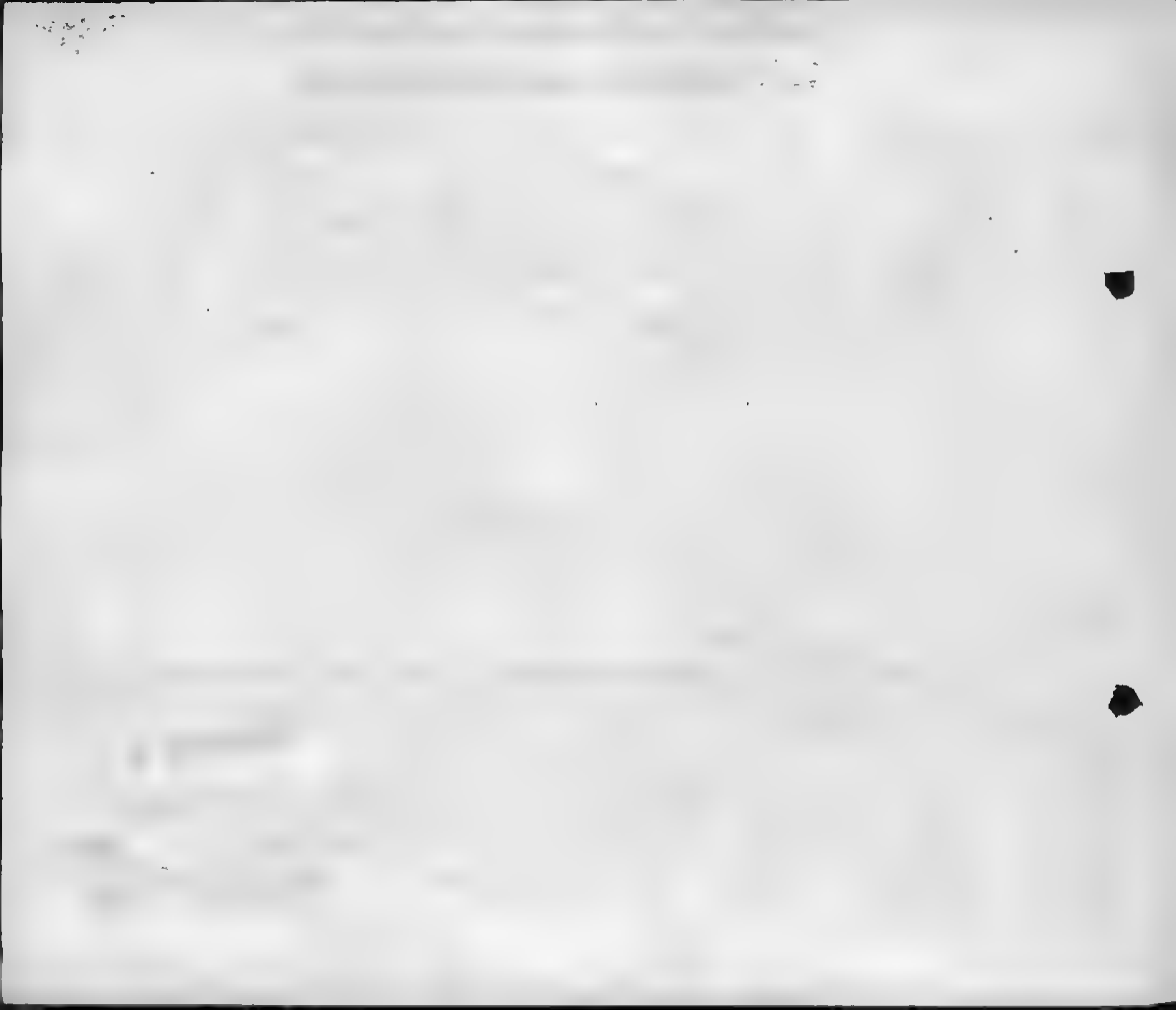
**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155C 1-55 JPM



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Formerly *Columbia, Pa*  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1481 CERTIFICATE OF DEATH

Reg. Dist. No.

01448

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>Pa.</i> COUNTY <i>Columbia</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Swanton</i>		TOWN <i>Swanton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Musburg Home</i>		STREET ADDRESS (If rural give location) <i>6811 Campfield Rd</i>	
3. NAME OF DECEASED (Type or Print) <i>Susanna H. Helt</i>	4. DATE (Month) (Day) (Year) OF DEATH <i>Feb 17 1956</i>		
5. SEX <i>F</i>	6. CO. OR 7. SINGLE MARRIED, WIDOWED, DIVORCED, <i>W</i>	8. DATE OF BIRTH <i>3/7/1893</i>	
9. AGE last birthday <i>62 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life) <i>None</i>	11. PLACE OF BIRTH (State or foreign country) <i>Columbia Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>None</i>	13. FATHER'S NAME: <i>Benjamin F. Hebley</i>	14. MOTHER'S MAIDEN NAME: <i>Anna Albright</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state date or dates of service)	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT'S ADDRESS <i>Records 6811 Campfield Rd</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Arterio-Sclerotic Heart Disease</i>		<i>2 yrs</i>	
ANTECEDENT CAUSE (B) <i>None</i>		<i>2 wks</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		<i>5 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan - 10</i> , 1956, to <i>Feb. 17</i> , 1956, that I last saw the deceased alive on <i>Feb 16</i> , 1956, and that death occurred at <i>6 P.</i> M. from the causes and on the date stated above.			
SIGNATURE <i>Paul L. Chambers</i>		DATE SIGNED <i>4-10-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>2/20/56</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Peter's</i>		LOCATION (City, town, or county) <i>Columbia Pa</i>	
DATE REC'D BY LOCAL REGISTRAR <i>February 18 1956</i>		REGISTRAR'S SIGNATURE <i>Paul L. Chambers</i>	
24. FUNERAL DIRECTOR <i>Paul L. Chambers</i>		ADDRESS <i>606711 Hatfield Rd</i>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01449

## 1393 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
OR TOWN <u>Baltimore (Rural)</u>		OR TOWN <u>Baltimore (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4412 Alan Drive</u>		STREET ADDRESS (If rural give location) <u>4412 Alan Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>William R. Hodges</u>		<u>2/27/1956</u>	
5. SEX: <u>M</u> 6. COLOR OR RACE: <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>2/16/62</u>	
9. AGE last birthday <u>94</u> yrs. 10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U. S. Customs Store</u>	
12. FATHER'S NAME: <u>Richard Hodges</u>		13. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		15. SOCIAL SECURITY NO. <u>--</u>	
16. INFORMANT & ADDRESS: <u>James R. Hodges 4412 Alan Drive</u>		17. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>			
ANTECEDENT CAUSE (S) (B) <u>Cardiac Hypertrophy</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cardiac Dilatation</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20C. WHERE DID (City or town) (County) (State)		20D. HOW DID INJURY OCCUR?	
20E. TIME (Month) (Day) (Year) (Hour) OF INJURY		20F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Feb 3, 1956</u> to <u>Feb 27, 1956</u> , that I last saw the deceased alive on <u>Feb 27, 1956</u> , and that death occurred at <u>9:05 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Vincent M. Messina</u>		ADDRESS <u>M.D. 1403 S. Charles St</u>	
DATE SIGNED <u>2-28-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/2/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>John F. Denny, Inc.</u>	
FUNERAL DIRECTOR <u>John F. Denny, Inc.</u>		ADDRESS <u>715 Light St.</u>	

202



1482 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Towson</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>952 Dulaney Valley Rd.</b>				STREET ADDRESS (If rural give location) <b>952 Dulaney Valley Road #4</b>			
<b>3. DECEASED</b> (Type or Print) <b>Mr. William L. Hooper</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>February 9th 1956</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 16, 1878</b>	<b>9. AGE last birthday</b> <b>77</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Auditor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Brundel Corp</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Luther E. Hooper</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Wheeler</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Anna E. Hooper, 952 Dulaney Valley Road</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b> <b>Coronary Thrombosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, lecture, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M.		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 1954 to Dec 1954, that I last saw the deceased alive on Dec 1954, and that death occurred at 2 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Denise McGrath</b>				<b>ADDRESS</b> (Street, city, town, state) <b>8358 Loch Raven Blvd. Baltimore, Maryland</b>		<b>DATE SIGNED</b> <b>2/9/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>2/11/1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>FEB 10 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Markel Cray</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>Leonard J. Ruck, 5305 Harford Road #11</b>			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55

1991



1483

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson 4</u>	LENGTH OF STAY (in this place) <u>4</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson 4 (Baynesville)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1801 Darrick Drive</u>	<u>1801 Darrick Drive</u>	STREET ADDRESS (If rural give location) <u>1801 Darrick Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>MARY SAPP HRIB</u>		DATE OF DEATH: <u>Feb. 6, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Nov. 18, 1890</u>
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Austria</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Charles Sapp</u>	
14. MOTHER'S MAIDEN NAME: <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Edu. Mchalek, Towson, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of pancreas</u>			<u>6 weeks</u>
ANTECEDENT CAUSE (B) <u>None</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>None</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/15, 1955</u> , to <u>2/6, 1956</u> ; that I last saw the deceased alive on <u>2/6, 1956</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John Burne Som</u>		DATE SIGNED <u>2/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 9, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		LOCATION (City, town, or county) (State) <u>Clarksburg, W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/9/56</u>		REGISTRAR'S SIGNATURE <u>U. G. Bacon</u>	
FUNERAL DIRECTOR <u>John Burne Som, Towson, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1484 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. <b>Spring Grove State Hospital</b>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <b>Catonsville 28</b>	<b>3 years 3 mo.</b>	TOWN <b>Baltimore 17</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital</b>		STREET ADDRESS (If rural give location) <b>133 W. Lanvale Street</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>Olive Davison Hubner</b>		<b>2 20 19 56</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH. <b>12/13/1867</b>
9. AGE last birthday <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Davison</b>		14. MOTHER'S MAIDEN NAME: <b>Sophie Bond</b>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT & ADDRESS: <b>Mrs. George Thomas 200 Ridgewood Rd., Baltimore, Md.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<b>3 hours</b>	
4 IMMEDIATE CAUSE (A) <b>Pneumonia</b>			
ANTECEDENT CAUSE (B) <b>Chronic brain syndrome associated with</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <b>senile brain disease</b>			
(C) <b>Arteriosclerosis, generalized</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-</b> , 19 <b>53</b> , to <b>2-20-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2-20-</b> , 19 <b>56</b> , and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>Sheila Wachsler</b>		DATE SIGNED <b>Spring Grove State Hospital Catonsville 28, Maryland 2-20-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		DATE THEREOF <b>2/23/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>		(State) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2-22-56</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Pickens</b>	
FUNERAL DIRECTOR <b>Wm. J. Pickens</b>		ADDRESS <b>Wm. J. Pickens</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



01453

MARYLAND

STATE DEPARTMENT OF HEALTH

## 1485 CERTIFICATE OF DEATH

Reg. Dist. No. *KV*

1. PLACE OF DEATH - COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		STREET ADDRESS (If rural, give location) <b>811 Somerset Street</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>ROBERT HUDSON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>February 28 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6/15/96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <b>59</b> yrs. If under 1 year Months Days Hours Min.
11. FATHER'S NAME <b>Albert Hudson</b>		11. BIRTHPLACE (State or foreign country) <b>Reading, Pennsylvania</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <b>Yes WW I</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. SOCIAL SECURITY No. <b>228-18-7987</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Brim</b>	
15. INFORMANT AND ADDRESS <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		16. DATE OF OPERATION <b>Sept. 24, 1955</b>	
17. MAJOR FINDINGS OF OPERATION <b>IMMEDIATE CAUSE: CARCINOMA OF PROSTATE WITH GENERALIZED BONY METASTASIS</b>		18. AUTOPSY? <b>No</b>	
19. DATE OF OPERATION <b>Sept. 24, 1955</b>		20. MAJOR FINDINGS OF OPERATION <b>IMMEDIATE CAUSE: CARCINOMA OF PROSTATE WITH GENERALIZED BONY METASTASIS</b>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Accident</b>		22. PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>VA</b>	
TIME (Month) (Day) (Year) (Hour) (Minute) <b>Feb. 28 1956 10:43A.</b>		HOW DID INJURY OCCUR? <b>While at Work</b>	
23. I hereby certify that <b>X</b> attended the deceased from <b>Sept. 24, 1955</b> , to <b>Feb. 28, 1956</b> , that I last saw the deceased <b>alive on Sept. 24, 1955</b> , and that death occurred at <b>10:43A. m.</b> , from the causes and on the date stated above.		24. SIGNATURE <b>D. D. MARK, M.D.</b>	
25. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		26. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>3/1/56 A.W. Hedrich</b>		27. FUNERAL DIRECTOR <b>Charles R. Law Mortuary, 802-04 Madison Av.</b>	
DATE SIGNED <b>2-29-56</b>		ADDRESS <b>Baltimore, Maryland</b>	

MARGIN RESERVED FOR BINDING



1486 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
TOWN <u>Fort Howard</u>	<u>15 Days</u>	TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>2 Chesapeake Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JAY (NMI) HUGUNIN</u>		OF DEATH <u>February 24 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>10/3/89</u>
9. AGE last birthday: <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Clintonville, Wis.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Foreman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Casimir Hugunin</u>		14. MOTHER'S MAIDEN NAME: <u>Jennie Moss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY No. <u>218 05 7621</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION?</u>		<u>SUDDEN</u>
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>CEREBRAL THROMBOSIS RIGHT MIDDLE CEREBRAL ARTERY WITH LEFT HEMIPLEGIA: PERNICIOUS ANEMIA</u>		

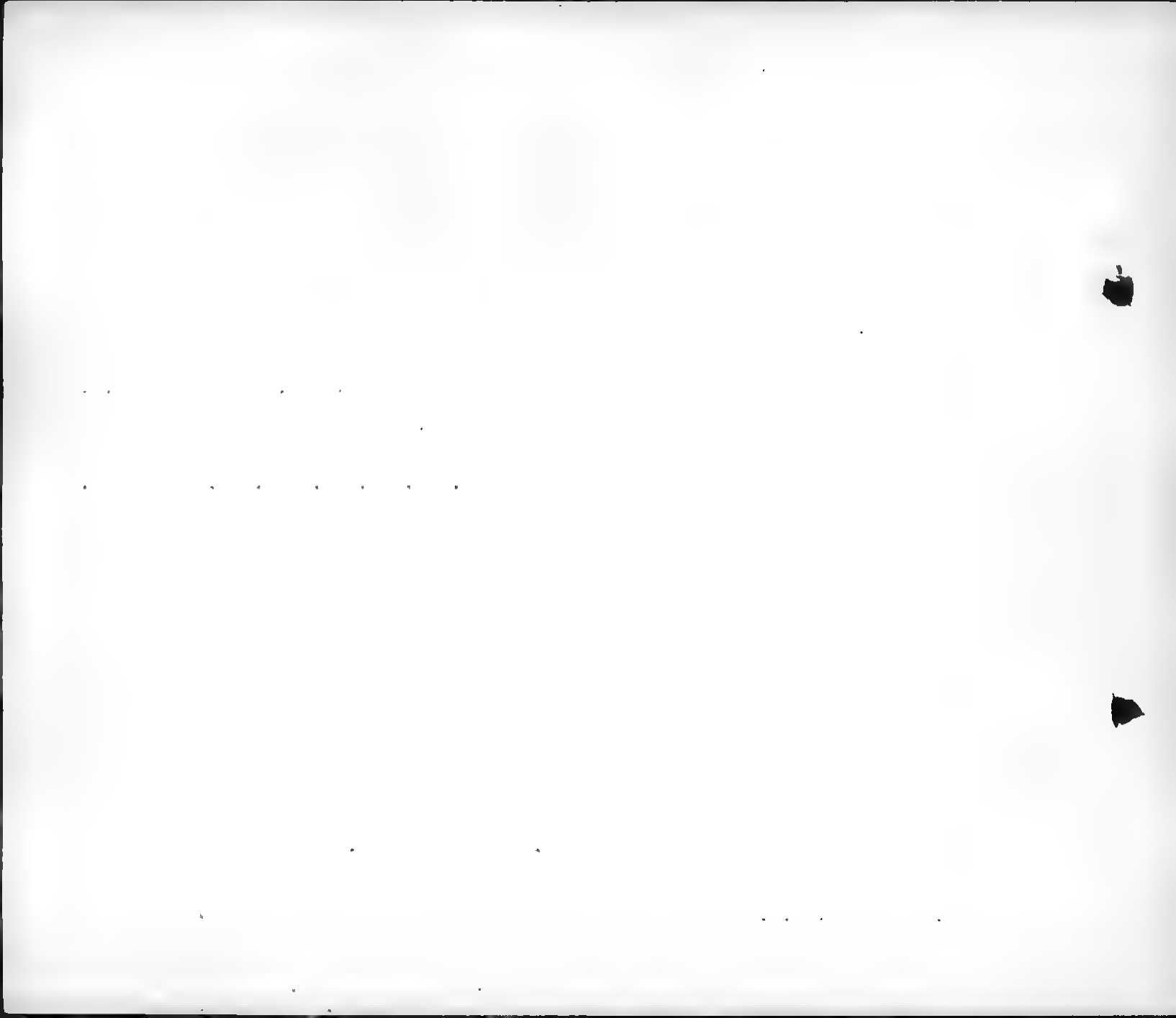
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Feb. 9, 1956</u> to <u>Feb. 24, 1956</u> and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John A. Surmonte</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>2-28-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-28-56</u>	<u>Baltimore National</u>	<u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>2/27/56</u>	REGISTRAR'S SIGNATURE <u>A. J. Heelrich</u>	24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Blight Inc. 6009 Harford Rd. Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1487

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonville</u>	LENGTH OF STAY (in this place) <u>36 hours</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington 27, DC</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hospital</u>		STREET ADDRESS (If rural give location) <u>503 - 65 Ave NE</u>	
3. NAME OF DECEASED: (First) <u>Benjamin</u> (Middle) <u>Newton</u> (Last) <u>Hutchinson</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> / <u>19</u> / <u>1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Oct. 23, 1887</u>
9. AGE last birthday <u>68</u> yrs		10. AGE last birthday (If UNDER 1 YEAR, Months Days Hours Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cabinet-maker</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Lemuel Hutchinson</u>		14. MOTHER'S MAIDEN NAME: <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT & ADDRESS: <u>This Hosp. records</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>450.0</u>		<u>unk.</u>	
ANTECEDENT CAUSE (B) <u>unk.</u>		<u>unk.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>General Arteriosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/18</u> , 19 <u>56</u> , to <u>2/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>56</u> , and that death occurred at <u>9:15 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Bruno Radauskas</u>		DATE SIGNED <u>2/19/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2-20-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		LOCATION (City, town, or county) <u>Washington 27, DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/23/56</u>		REGISTRAR'S SIGNATURE <u>V. E. Haring</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>1111 11th St. N.E.</u>	

RECEIVED

FEB

1961

1488

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		LENGTH OF STAY (In this place) <u>1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>5412 Pembroke Ave (16)</u>			
3. NAME OF DECEASED (Type or Print) <u>Nannie S. Jenkins</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 10, 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Nov. 22, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Fredrick H. Jenkins Phoenicia, Md</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic failure of heart</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cerebrovascular thrombosis</u>				(C) <u>4 days</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1</u> , 19 <u>52</u> , to <u>Feb 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 9</u> , 19 <u>56</u> , and that death occurred at <u>10</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>W. E. Byers</u>				M.D. <u>4605 Edmore Ave</u>		DATE SIGNED <u>2/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>Travis Presbyterian</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>—</u>		REGISTRAR'S SIGNATURE <u>T. E. Byers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u>		ADDRESS <u>5005 E. Light St Balto 15, Md</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V-4-AISC 1-55 10M

FFB

Items 3, 13, 14, 16: Film 1489  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 30

1. PLACE OF DEATH: <b>Spring Grove State Hospital</b>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Harford</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Catonsville 28</b>	LENGTH OF STAY (in this place) <b>2 mos.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Havre de Grace</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital</b>		STREET ADDRESS (If rural give location) <b>Route #1</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Bruce ROBERT BRUCE Johnson</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>2 20 1956</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>2 - 10 - 82</b>
9. AGE last birthday: <b>74</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>ex-farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>Byron Johnson, Byron</b>		14. MOTHER'S MAIDEN NAME: <b>Rosie/ Rosa Boyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <b>unk.</b>		16. SOCIAL SECURITY NO.: <b>Unknown 9122A</b>	
17. INFORMANT & ADDRESS: <b>Miss Dona Johnson, Route #1 Havre de Grace, Md.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		9 days	
IMMEDIATE CAUSE (A) <b>Pneumonia, terminal</b>			
ANTECEDENT CAUSE (B) <b>Arteriosclerosis, generalized</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Cerebral thrombosis with left hemiparesis</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-21-1955</b> , to <b>2-20-1956</b> , that I last saw the deceased alive on <b>2-20-1956</b> , and that death occurred at <b>9:50P M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Stella Wadeler</b>		DATE SIGNED <b>2-21-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		NAME OF CEMETERY OR CREMATORY <b>Rock Run Cr. Harford Co Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2/21/56</b>		24. FUNERAL DIRECTOR <b>A S Bailey, Baltimore Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 28 1966

5501

## MARYLAND STATE DEPARTMENT OF HEALTH

1490

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

Item 9, File GL93 3-6-56 et

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHATHAONEE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHATHAONEE</u>	
TOWN <u>CHATHAONEE</u>		TOWN <u>CHATHAONEE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VALLEY ROAD</u>		STREET ADDRESS (If rural, give location) <u>VALLEY ROAD</u>	
3. NAME OF DECEASED (Type or Print) <u>HIRAN</u> (First) <u>SORRELL</u> (Middle) <u>JONES</u> (Last)		4. DATE OF DEATH <u>2-10-56</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>6-16-1896</u> (Month) (Day) (Year)
9. AGE last birthday <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS H. JONE</u>		14. MOTHER'S MAIDEN NAME <u>ELLA BUTLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Fuller 111111 - 111111</u>	
17. INFORMANT AND ADDRESS <u>Fuller 111111 - 111111</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs.</u>
Immediate cause (a) <u>accidental Drowning</u>		
Antecedent cause(s) (b) <u>Epilepsy</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None.</u>		
19a. DATE OF OPERATION <u>None.</u>	19b. MAJOR FINDINGS OF OPERATION <u>None.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. PRIMARY OR CONTRIBUTING CAUSE OF DEATH		
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2 6 56 A.M.</u>	PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY <u>Spring in woods, Harrison</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Balto. Md</u>
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Had seizure &amp; drowned in spring.</u>

22 I certify that I took charge of the remains described above, held an Autopsy, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

D.D. CaplesM.D.Riverton, Md2-10-56

DATE RECEIVED BY LOCAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/11/56Barry A. SmithTravis H. Powell Co.Ind.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01459

## 1491 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		COUNTY <u>Baltimore</u>			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 TOWN Catonsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3 Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Dunvegan Rd.</u>				STREET ADDRESS (If rural give location) <u>38 Dunvegan Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Archie Owens</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb. 1, 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 25, 1981</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Owens</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Aubrey O Kane 38 Dunvegan Rd.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Myocardial Decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>17mo</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Hypertensive Cardio-Vasc - Renal Disease</u>				<u>10yr</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2:00 P.M.</u> , 19 <u>55</u> , <b>to</b> <u>2:10</u> , 19 <u>56</u> , <b>that I last saw the deceased alive on</b> <u>2-2</u> , 19 <u>56</u> , <b>and that death occurred at</b> <u>7:00 A.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>William R. Gallagher</u> <b>DATE SIGNED</b> <u>2/11/56</u> <b>ADDRESS</b> (Street, city, town, state) <u>M. 62097 Frederick Rd Balt. 28, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <u>T. G. H. H.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Foley Funeral Home, Catonsville, Md.</u>		ADDRESS	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct type is especially important. Physicians: please write the causes of death clearly and legibly.

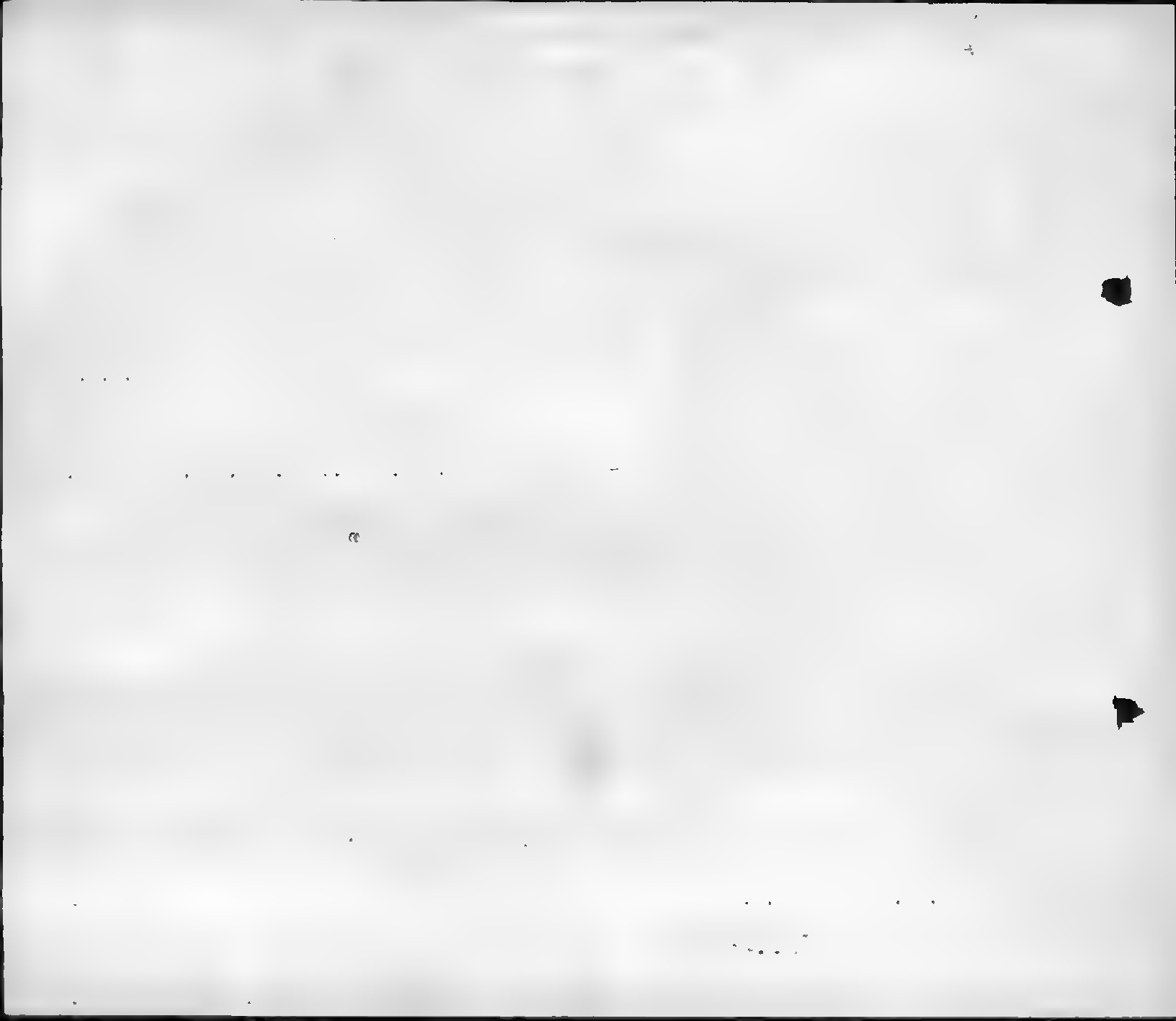
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1492 CERTIFICATE OF DEATH

Reg. Dist. No.

01460

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>15 hrs; 15 min.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>		STREET ADDRESS (If rural give location) <b>517 N. Loudon Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>OSCAR S. KEIM</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>February 22, 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>	8. DATE OF BIRTH <b>May 14, 1874</b>
9. AGE last birthday: <b>81</b> yrs		10. BIRTHPLACE (State or foreign country) <b>Tunkhannock, Pennsylvania</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Storekeeper's Clerk</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin Keim</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Vosburg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <b>Yes</b> <b>SAW</b>		16. SOCIAL SECURITY NO. <b>207-01-7523</b>	
17. INFORMATION & ADDRESS <b>Vet. Adm. Hosp. Clin. Rec., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <b>ARTERIOSCLEROTIC HEART DISEASE</b>		<b>9 MONTHS</b>	
(B) ANTECEDENT CAUSE (S): <b>GENERALIZED ARTERIOSCLEROSIS</b>		<b>UNKNOWN</b>	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<b>5 YEARS</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that <b>VA</b> attended the deceased from <b>Feb. 21, 1956</b> , to <b>Feb. 22, 1956</b> , and that death occurred at <b>2:15 AM</b> , from the causes and on the date stated above.			
SIGNATURE <b>W. C. Dudley, M.D.</b>		ADDRESS <b>VAH, Fort Howard, Maryland</b>	
DATE SIGNED <b>2-22-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>FEB. 24, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>23, 1956</b>		REGISTRAR'S SIGNATURE <b>Witzke Funeral Directors</b>	
24. FUNERAL DIRECTOR <b>Witzke Funeral Directors</b>		ADDRESS <b>4101 Edmondson Ave., Baltimore, Md.</b>	



1493 Item 12, Film 192 2-20-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. NAME OF DECEASED (Type or Print) Clara King			2. DATE OF DEATH Feb 11, 1956		
3. PLACE OF DEATH: A. Baltimore, Maryland Baltimore County			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) The House in the Pines Rd 16 Fusting Ave, Catonsville			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2601 Madison Ave. Temple Garden Apt					
C. Length of stay in Baltimore Yrs. Mos. Days					
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Aug 1, 1867		9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany		12. CIT. ZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Raphael Wolf			14. MOTHER'S MAIDEN NAME Rosina Sonneberg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Louis Rosenstein, 2601 Madison Ave		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphensia, etc. It means the disease, injury or complication which caused death.) DUE TO Acute Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO Atherosclerosis - Sclerosis - Chronic Coronary Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 1 hour
19A. DATE OF OPERATION Feb. 11, 1956		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1956 to Feb. 9, 1956, that (I) (we) last saw the deceased alive on Feb. 9, 1956, and that death occurred at 12:45 p.m., from the causes and on the date stated above.					
23A. SIGNATURE David R. Cohen		23B. ADDRESS The Maryland Apt		23C. DATE SIGNED 2-11-56	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-13-56	24C. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25. FUNERAL DIRECTOR David R. Martin		ADDRESS David R. Martin, 1902 Rutaw Place			

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information the carefully supplied. Physicians: please write the causes of death clearly and leg-  
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

ML CERTIFICATION

RECEIVED

FEB 16 1956

BUREAU V. S.

## 1494 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>10 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>331 Oella Avenue</u>				STREET ADDRESS (if rural give location) <u>331 Oella Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGIA</u> (First) <u>KNABE</u> (Last)				4. DATE OF DEATH <u>February 8</u> 19 <u>56</u> . (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>February 9, 1880.</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Judson Boswell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ann Severen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Ernest Knabe</u> <u>Route 3, Box 40</u> <u>Ellicott City, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
191X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>-</u>							
(C) <u>-</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/6</u> , 19 <u>56</u> , to <u>2/8</u> , 19 <u>56</u> that I last saw the deceased alive on <u>2/7</u> , 19 <u>56</u> , and that death occurred at <u>3</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>George E. Buntorf</u> M.D.				ADDRESS (Street, city, town, state) <u>Church St. Ellicott City, Md.</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 11, 1956.</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>		LOCATION (City, town, or county) (State) <u>Ellicott City, Maryland.</u>	
24. REC'D BY REGISTRAR <u>2/9/56</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Carston Sord</u> ADDRESS <u>Catonsville 28, Md.</u>			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M





1394

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Relay</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Viaduct Ave.</b>		d. STREET ADDRESS <b>Viaduct Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Emory E. Knode, Sr.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1880</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O.R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Knode</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles B. Knode</b>		Address <b>Relay 27<sup>nd</sup> 1007 Francis Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of Bladder</b> DUE TO (b) <b>General Carcinomatosis</b> DUE TO (c) <b>Myocardial Infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b> <b>6 mo</b> <b>1 mo</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 1950</b> to <b>Feb. 25, 1956</b> that I last saw the deceased alive on <b>Feb. 25, 1956</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>56 69<sup>th</sup> Main St. 2127<sup>th</sup></b> DATE SIGNED <b>Feb. 27, 1956</b> ACTUAL SIGNATURE <b>R. B. Brumbaugh M.D.</b> PHYSICIAN'S NAME (Type) <b>E. E. Bridge 27<sup>th</sup> Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose Inc. 1328 Sulphur Spring Rd.</b>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <b>Dr. Geo. F. M. Lippert</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01464

1495

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Sparrows Point</b>		LENGTH OF STAY (In this place) <b>47 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Sparrows Point</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7409 North Point Road</b>				STREET ADDRESS (If rural, give location) <b>7409 North Point Road</b>			
3. NAME OF DECEASED (Type or Print)		(First) <b>JOHN</b>		(Middle) <b>OSCAR</b>		(Last) <b>KOLSTROM</b>	
4. DATE OF DEATH		(Month) <b>Feb. 12</b>		(Day) <b>19</b>		(Year) <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec. 25, 1890</b>		9. AGE last birthday <b>65</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heater</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Finland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Kolstrom</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY No. <b>213-07-2883</b>		17. INFORMANT <b>Mrs. Hilma Kolstrom 7409 North Point Road</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4 Immediate cause (a) <b>Coronary Thrombosis</b>		<b>2 hrs</b>	
Antecedent cause(s) (b) <b>Arteriosclerotic Ht. Disease</b>		<b>3 yrs</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Oct**, 19**55**, to **Feb. 12**, 19**56**, that I last saw the deceased alive on **Feb. 12**, 19**56**, and that death occurred at **2:00 A.M.**, from the causes and on the date stated above.

SIGNATURE <b>James T. Means</b>		(Degree or title)		ADDRESS <b>5200 St. Balt. 19 Md</b>		DATE SIGNED <b>2/13/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE <b>Feb. 15, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		LOCATION (City, town, or county) (State) <b>Colgate, Md.</b>	
DATE REC'D BY LOCAL REG. <b>Feb. 13-56</b>		REGISTRAR'S SIGNATURE <b>Samuel L. Harbor</b>		24. FUNERAL DIRECTOR <b>Ullrich Funeral Home</b>		ADDRESS <b>2112 Dundalk Ave.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1496 CERTIFICATE OF DEATH

01465

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Alto.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>100.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>				STREET ADDRESS (If rural give location) <u>210 Shady Nook Court</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Arnold</u> <u>Inhoff</u> <u>Doelle</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>17</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>July 11, 1900</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garbener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Wisc.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fred Kopelke</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Hardt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>William Kopelke 210 Shady Nook</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
44a. IMMEDIATE CAUSE (A) <u>Myocardial Decompensation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertension, Cor. Vasc. - Renal Disease</u>				<u>5 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Night <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-08</u> , 19 <u>53</u> , to <u>2-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William K. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M.D. Catonsville-28, Md.</u>		DATE SIGNED <u>2-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>		LOCATION (City, town, or county) (State) <u>100.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V. E. Harney</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>FEB 23 1956</u>							

RECEIVED  
FEB 1 1956

## 1497 CERTIFICATE OF DEATH

Reg. Dist. No. . . . .

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SPARROWS POINT (19)</u>		<u>30 YRS</u>		TOWN <u>SPARROWS POINT (19)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RURAL ROUTE BOX #302</u>				STREET ADDRESS (If rural give location) <u>RURAL ROUTE 10 - BOX #302</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>WILBUR GEORGE KYLE</u>				OF DEATH <u>FEB. 24 1956</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>JULY 22, 1874</u>	
9. AGE last birthday: <u>82</u> yrs.		10. UNDER 1 YEAR: Months Days		11. UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLWRIGHT HELPER</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>STEEL MFR</u>		11. BIRTHPLACE (State or foreign country): <u>W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>JOHN KYLE</u>				14. MOTHER'S MAIDEN NAME: <u>SARAH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-07-6675</u>		17. INFORMANT & ADDRESS: <u>JAMES W. KYLE 3446 MESHAKE WAY DUNDALK 22, MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						<u>3 days.</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic Cardio-vascular Disease.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 6, 1956</u> , to <u>Feb. 24, 1956</u> , that I last saw the deceased alive on <u>Feb. 23, 1956</u> , and that death occurred at <u>2:15</u> A M, from the causes and on the date stated above.							
SIGNATURE <u>David P. Davis, M.D.</u>		ADDRESS <u>9142 St. Balto. 19 Md.</u>		DATE SIGNED <u>2/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1956</u>		REGISTRAR'S SIGNATURE <u>Richard L. Leary, Walter R. Leary, Randolph, Md.</u>		24. FUNERAL DIRECTOR ADDRESS			

RECEIVED N. C.

21

1917



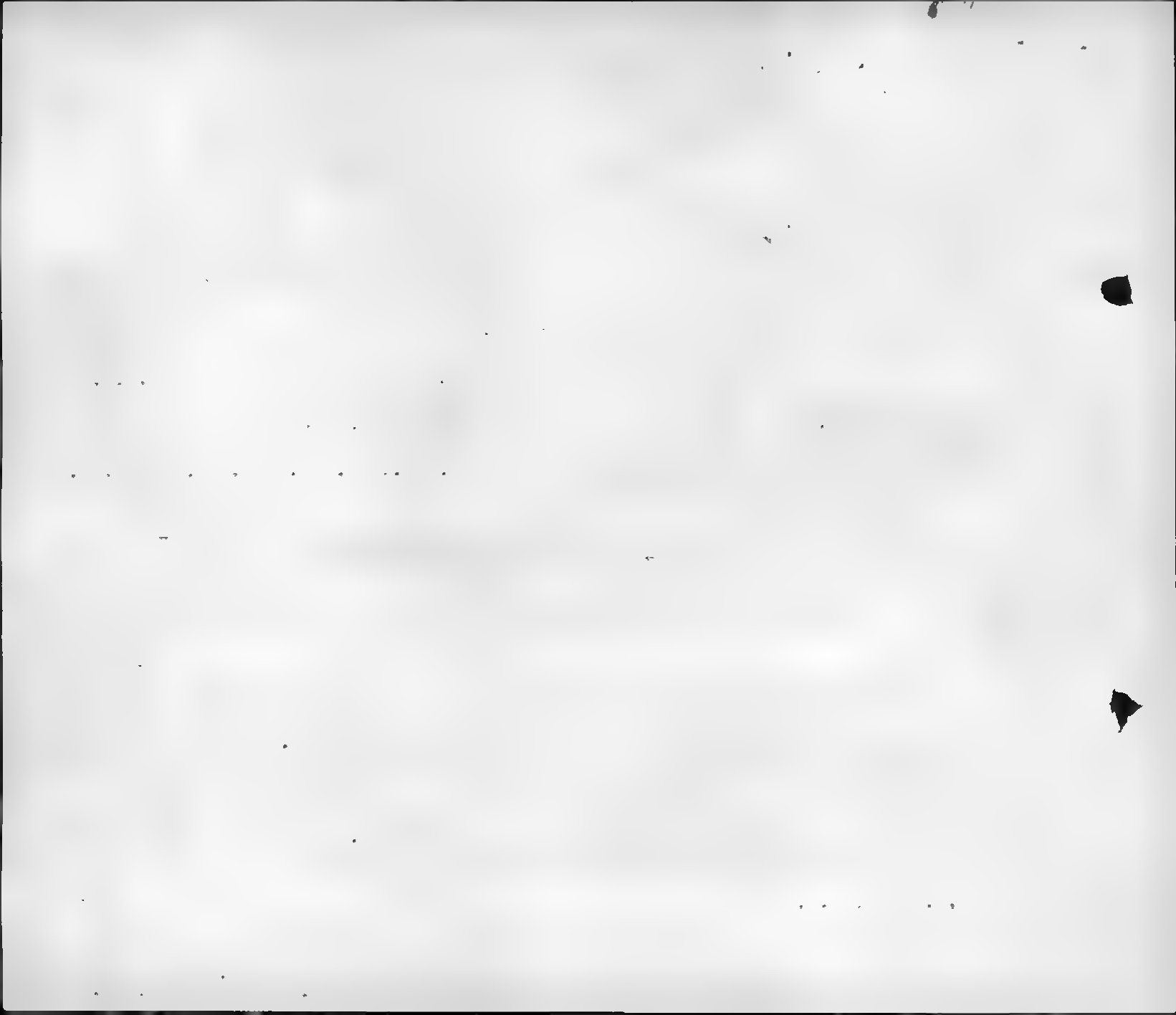
## 1498 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u> LENGTH OF STAY (in this place) <u>87 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>JESSUPS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>Box 54</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JOSEPH (Juozapas) (MI) LATVANAS</u>		OF DEATH: <u>February 12</u> <u>1956</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8-18-23</u>
9. AGE last birthday: <u>62</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Latvanas</u>		14. MOTHER'S MAIDEN NAME: <u>Eva (MN: Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>INFARCTION OF MYOCARDIUM DUE TO ARTERIO</u>			
ANTECEDENT CAUSE (B) <u>EX EXT: SCLEROTIC CORONARY THROMBOSIS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>002LX</u> (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
(C) <u>PULMONARY TUBERCULOSIS</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>38 YEARS</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1955</u> , to <u>Feb. 12, 1956</u> , that I last saw the deceased <u>alive on 12-10-56</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. B. COPELAND</u>		DATE SIGNED <u>2-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-15-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-14-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>William Cook-Blight Inc.</u>		ADDRESS <u>6009 Harford Ave., Baltimore 11, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1499 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chase, Md.</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chase, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Ave</u>				STREET ADDRESS (If rural give location) <u>Eastern Ave</u>			
3. NAME OF DECEASED:		(First) <u>Hate</u>		(Middle) <u>Lay</u>		(Last) <u>Haas</u>	
(Type or Print)							
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 25<sup>th</sup> 1866</u>	9. AGE last birthday: <u>89</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>John Reinhardt</u>				14. MOTHER'S MAIDEN NAME: <u>Hate Haas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Catherine Chenoweth</u>			
(If Yes, give war or dates of service)				<u>329 1/2 Chester Ave. Balto. 18</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Lobar Pneumonia</u>						<u>1 day</u>	
Antecedent causes (s) DUE TO (b) <u>arteriosclerotic Cardiovascular disease</u>						<u>2 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Feb 2</u> , 1956, to <u>Feb 6</u> , 1956, that I last saw the deceased alive on <u>Feb 6</u> , 1956, and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. B. Gardner</u>				ADDRESS <u>Balto. Md.</u>		DATE SIGNED <u>2/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/10/56</u>		<u>St. Michaels Luth.</u>		<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 7 1956</u>		<u>G. W. Hedrick</u>		<u>Larrah Funeral Home</u>		<u>7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1500

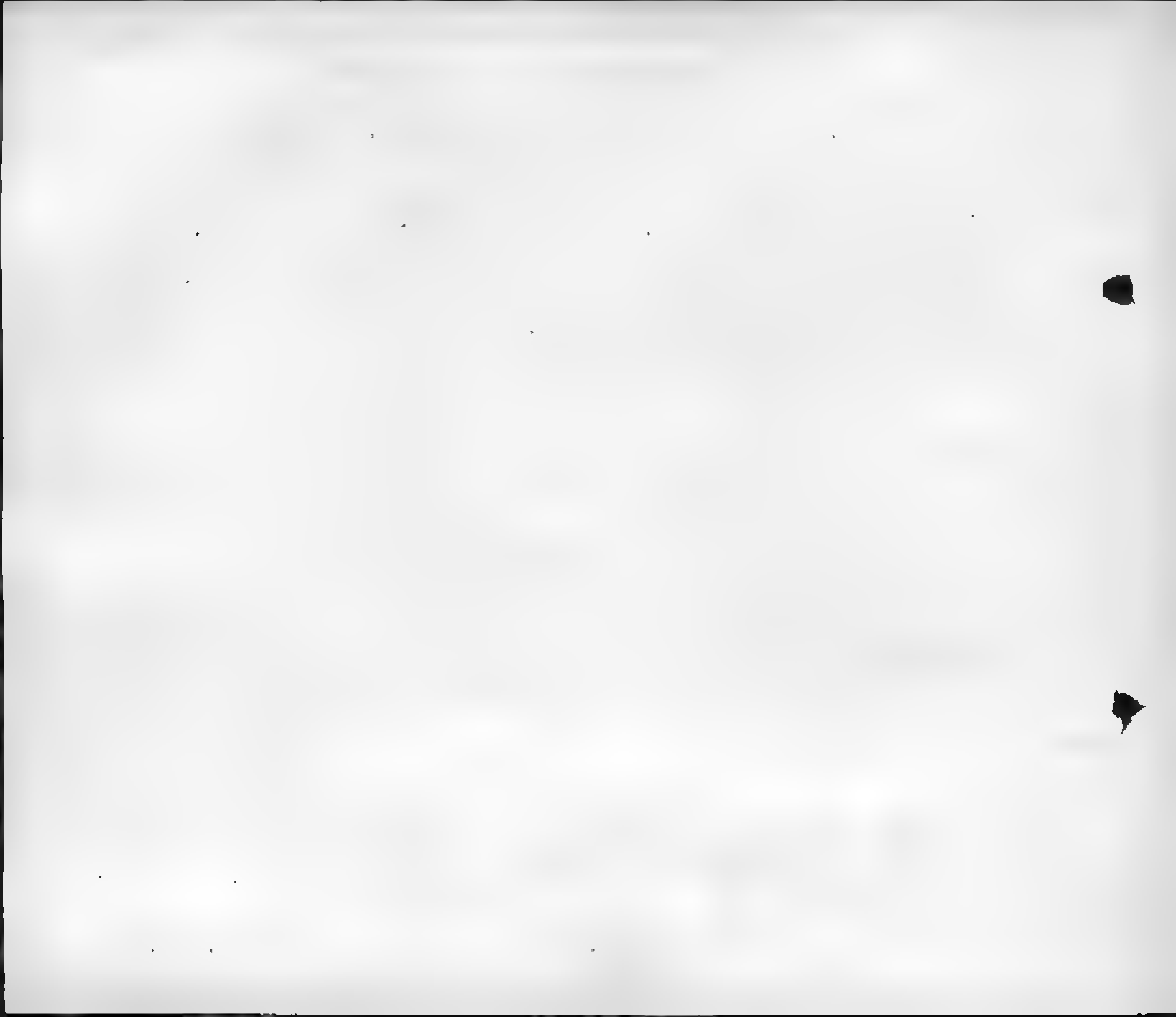
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Catonsville</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>16 Fusting Ave.</b>				STREET ADDRESS (If rural give location) <b>1656 Northgate Rd.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>CLARA B. LEASE</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Feb. 18 19 56</b>			
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH: <b>Oct. 5, 1869</b>	9. AGE last birthday: <b>86</b> yrs	10. UNDER 1 YEAR: Months	11. UNDER 24 HRS.: Days	12. UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>at home</b>		11. BIRTHPLACE (State or foreign country): <b>Md.</b>	
13. FATHER'S NAME: <b>John Gwynn Tibbals</b>				14. MOTHER'S MAIDEN NAME: <b>-</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				18. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS: <b>Mr. H. Gwynn Lease-1656 Northgate Rd.</b>	
15. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Myocardial Infarction</b>							<b>10 da.</b>
ANTECEDENT CAUSE (B) <b>Ch. Hypertensive Cardis. Vascular Disease</b>							<b>15 yrs.</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-4, 1955, to 2-16, 1956, that I last saw the deceased alive on 2-18, 1956, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE <b>William K. Gallagher</b>		ADDRESS <b>M. D. Catonsville-282nd</b>		DATE SIGNED <b>2-20-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/21/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Feb 24 1956</b>		REGISTRAR'S SIGNATURE <b>G. H. Hedrick</b>		FUNERAL DIRECTOR <b>Wm. J. Lichten</b>		ADDRESS <b>Sons. Balto 17th</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1501

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH - COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Ind</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hawblesburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hawblesburg</u>	
TOWN <u>Hawblesburg</u>		TOWN <u>Hawblesburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EMMA - ETTA - LEIGHT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 14 1956</u>	
5. SEX <u>H</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13-1896</u>
9. AGE last birthday <u>59</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A Myers</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>MI</u>	
17. INFORMANT AND ADDRESS <u>Blanche Leight, Hawblesburg Ind</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Artery Disease</u>		<u>1 hr</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Varicose Veins.</u>		<u>20 yrs.</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>None</u>	
(CITY OR TOWN) <u>None</u>		(COUNTY) <u>None</u>	
(STATE) <u>None</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>	
HOW DID INJURY OCCUR? <u>None</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>D.D. Caples</u>		DATE SIGNED <u>2-15-56</u>	
(Degree or title)		(Address)	
<u>MD</u>		<u>Reisterstown, Ind.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>Feb 12/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Cremory</u>		LOCATION (City, town, or county) (State) <u>Reisterstown Ind</u>	
DATE REC'D BY LOCAL REG. <u>2-16-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Elme</u>	
24. FUNERAL DIRECTOR <u>Edw. Clifton</u>		ADDRESS <u>Hawblesburg Ind</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 10 1964



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01472

1502 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Alice Louise Tennent</i>			2. DATE OF DEATH <i>2/12/56</i>		
3. PLACE OF DEATH: A. <i>Baltimore, Md.</i> Maryland - <i>Stoneleigh</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>812 Register Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>5500 Lombardy Place</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug 29 1878</i>	9. AGE (In years last birthday) <i>73</i>	10. Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Care Home</i>	11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Browne</i>			14. MOTHER'S MAIDEN NAME <i>Katherine Sloane</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mrs. Randolph Mcklenrich</i>		

18. <i>1974</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Carcinoma, Head of Pancreas with jaundice</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST (B) <i>Arteriosclerotic Cardio-vascular Disease</i> DUE TO		<i>2 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cerebral Vascular Accident</i>		<i>1 yr.</i>

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that (I) (this hospital) attended the deceased from *Dec. 1954* to *Feb. 1956*, that (I) (no) last saw the deceased alive on *Feb. 10, 1956*, and that death occurred at *10 A.* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Wm H. Hammer, Jr.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23B. ADDRESS <i>5015 Highland Ave.</i>	23C. DATE SIGNED <i>2/13/56</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/15/56</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	24D. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i>
------------------------------------------------------------	-----------------------------	-------------------------------------------------------	----------------------------------------------------------------------

DATE RECEIVED BY LOCAL REGISTRAR <i>2-15-56</i>	REGISTRAR'S SIGNATURE <i>A.W. Hedrick</i>	25 FUNERAL DIRECTOR <i>Wm Cook, Inc.</i>	ADDRESS <i>1217 St. Paul st.</i>
----------------------------------------------------	----------------------------------------------	---------------------------------------------	-------------------------------------

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01473

## 1593 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Prince Georges</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <b>Owings Mills</b>		<b>2 yrs.</b>		TOWN <b>Hyattsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood State Tr. School</b>				STREET ADDRESS (If rural give location) <b>8215-14th Avenue</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>Phillip Levine</b>				<b>2 2 19 56</b>			
5. SEX	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<b>male</b>	<b>white</b>	<b>single</b>	<b>6/29/53</b>	<b>2</b> yrs.	Months	Days	Hours Min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<b>Washington, D.C.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME			
<b>Leo Levine</b>				<b>Shirley Breslow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<b>Rosewood Records</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<b>471X</b>							
IMMEDIATE CAUSE				(A) <b>Pneumonitis</b>			
ANTECEDENT CAUSE (B)				DUE TO <b>Hydrocephaly</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Malnutrition</b>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE OLD (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2/1</b> , 19 <b>56</b> , to <b>2/2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/2</b> , 19 <b>56</b> , and that death occurred at <b>9:00 a.m.</b> from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<b>Mary B. Butler</b>				<b>Owings Mills, Md.</b>		<b>2/2/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<b>REMOVAL</b>				<b>2-2-56</b>		<b>Wash. D.C.</b>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR	
<b>2-2-56</b>				<b>Mary B. Butler</b>		<b>Goldberg Funeral Home 4217-9th St NW Wash DC</b>	

INTERVAL BETWEEN ONSET AND DEATH

**24 hrs.**

since birth

3 A TITAN

01474

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Form 933-1-56 et

## CERTIFICATE OF DEATH

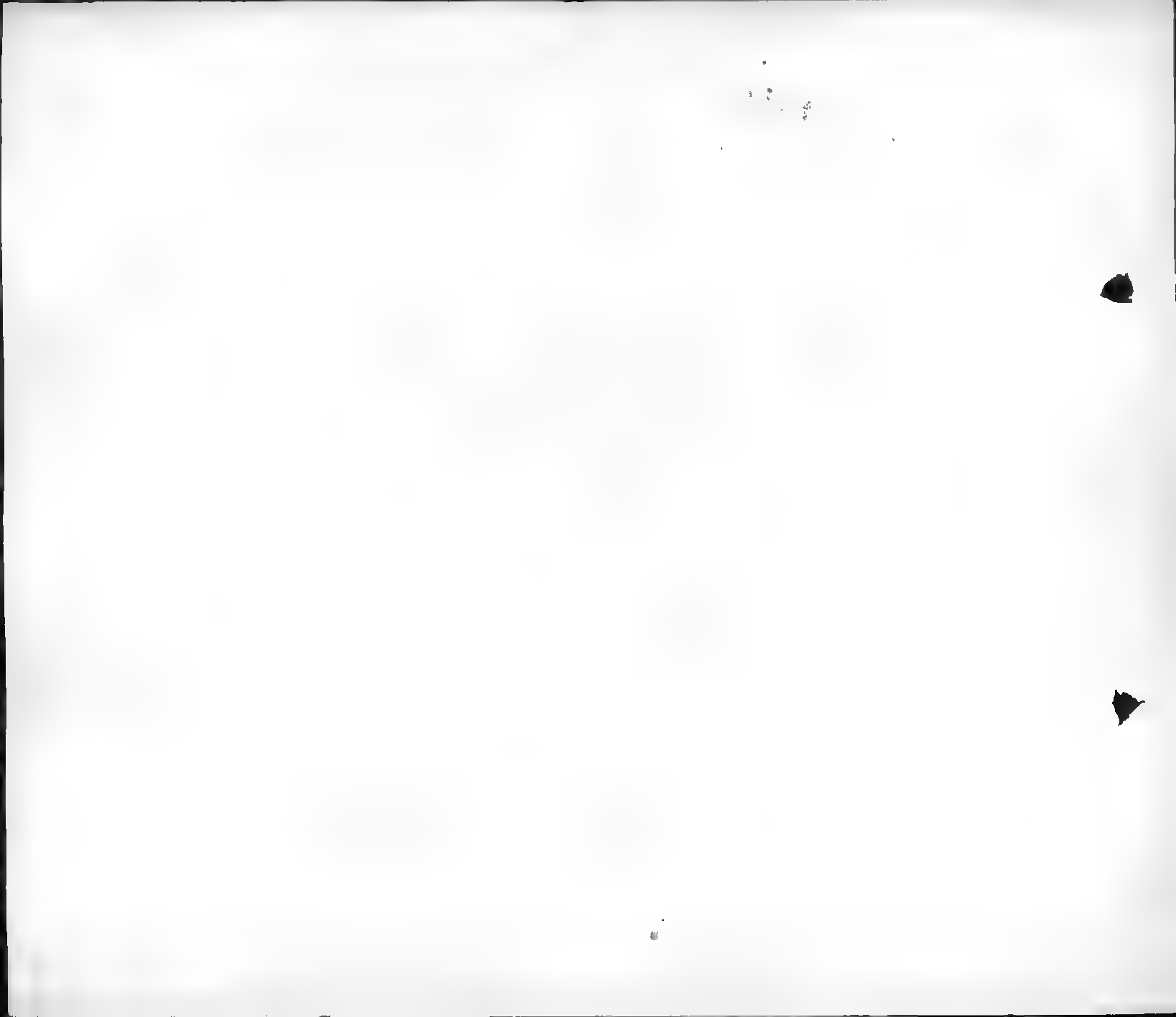
Reg. Dist. No.

32

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u> 15 years HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Orchard Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville &amp; Md.</u> STREET ADDRESS (If rural give location) <u>Orchard Rd.</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Bridget Agnes Lingg</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb 14</u> 19 <u>56</u>	
5. SEX: <u>Female</u> 6. COLOR OR RACE: <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u> 8. DATE OF BIRTH: <u>Oct 15, 1884</u> 9. AGE last birthday (If under 1 year, Months Days; If under 24 hrs, Hours Min.) <u>70 yrs.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> 10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Ireland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Patrick Dougherty</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Donnelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY No: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Benjamin Lingg, Orchard Rd Pikesville &amp; Md.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u> ANTECEDENT CAUSE (B) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 Nov</u> , 19 <u>53</u> , to <u>14 Feb</u> , 19 <u>56</u> that I last saw the deceased alive on <u>14 Feb</u> , 19 <u>56</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above. SIGNATURE <u>Paul H. Rouse</u> ADDRESS <u>M.D. Pikesville &amp; Md.</u> DATE SIGNED <u>14 Feb 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>Febr 17, 1956</u> NAME OF CEMETERY OR CREMATORY <u>Green Ridge Cemetery</u> LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>Frank H. Howell, Pikesville</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01475

## 1575 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff Md. near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenview Rd</u>		STREET ADDRESS <u>Glenview Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Dr. M. Catalicia Magin</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>26</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 7 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Rochester N.Y.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. CITIZEN OF WHAT COUNTRY? <u>RELIGIOUS.</u>	
13. FATHER'S NAME <u>Martin Magin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Engbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>St. Mary Clara NOTCH CLIFF NR TOWSON, MD.</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
19. IMMEDIATE cause (a) <u>Respiratory failure due to metastasis</u>		<u>1 wk</u>
20. ANTECEDENT cause(s) (b) <u>Carcinoma of ascending colon</u>		<u>5 yrs.</u>
(c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 22, 1953, to Feb. 26, 1956, that I last saw the deceasedalive on Feb. 21, 1956, and that death occurred at 12:50 P. m., from the causes and on the date stated above.SIGNATURE Charles S. Taylor (Degree or title) ADDRESS 7501 YORK RD. TOWSON, MD. 2-26-56. DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>2-28-56</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2-28-56</u>	<u>Charles S. Taylor</u>	<u>9015 CONKLIN ST.</u>	<u>BALTO., MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

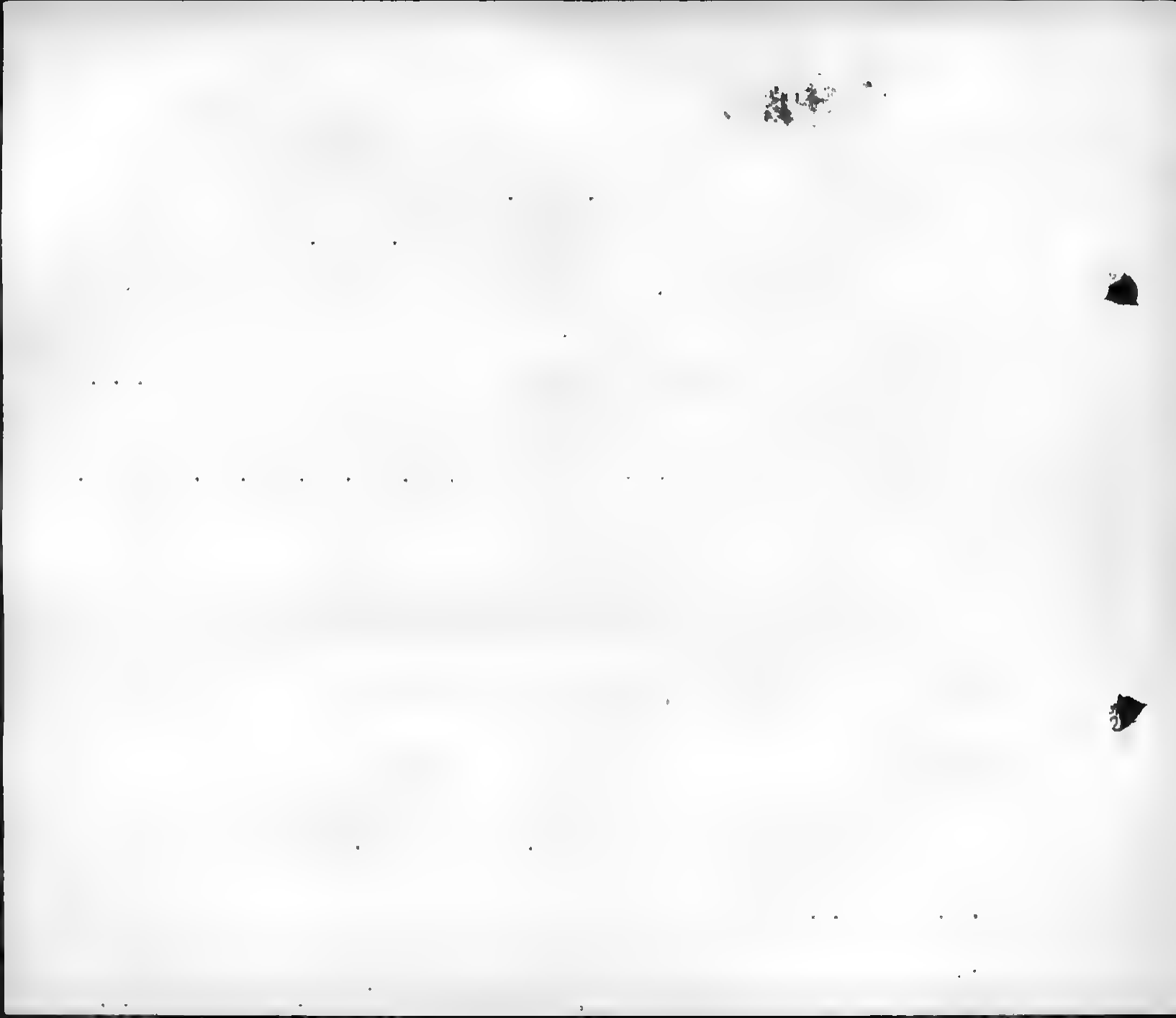




## 1506 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>FORT HOWARD</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ANNAPOLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>Rt. #4, St. MARGARETTES</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>AUGUST</u> <u>CARI</u> <u>MATTES</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>February 10,</u> <u>19 56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE MARRIED WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH <u>9-10-91</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>CHRISTIAN MATTES</u>				14. MOTHER'S MAIDEN NAME: <u>HERMOINE BREINING</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>			16. SOCIAL SECURITY NO. <u>213-01-9778</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>APLASTIC ANEMIA</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 10, 1956, to Feb. 10, 1956, and that death occurred at 11:25 PM, from the causes and on the date stated above.							
SIGNATURE <u>C. D. Mark, M.D.</u>			ADDRESS <u>VAH, Fort Howard, Maryland</u>			DATE SIGNED <u>2-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			DATE THEREOF <u>2/14/56</u>			NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
LOCATION (City, town, or county) <u>Baltimore, Maryland</u>							
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Funeral Home</u>			ADDRESS <u>5309 Harford Rd., Baltimore, Md.</u>				



## 1507 CERTIFICATE OF DEATH

Reg. Dist. No. 37

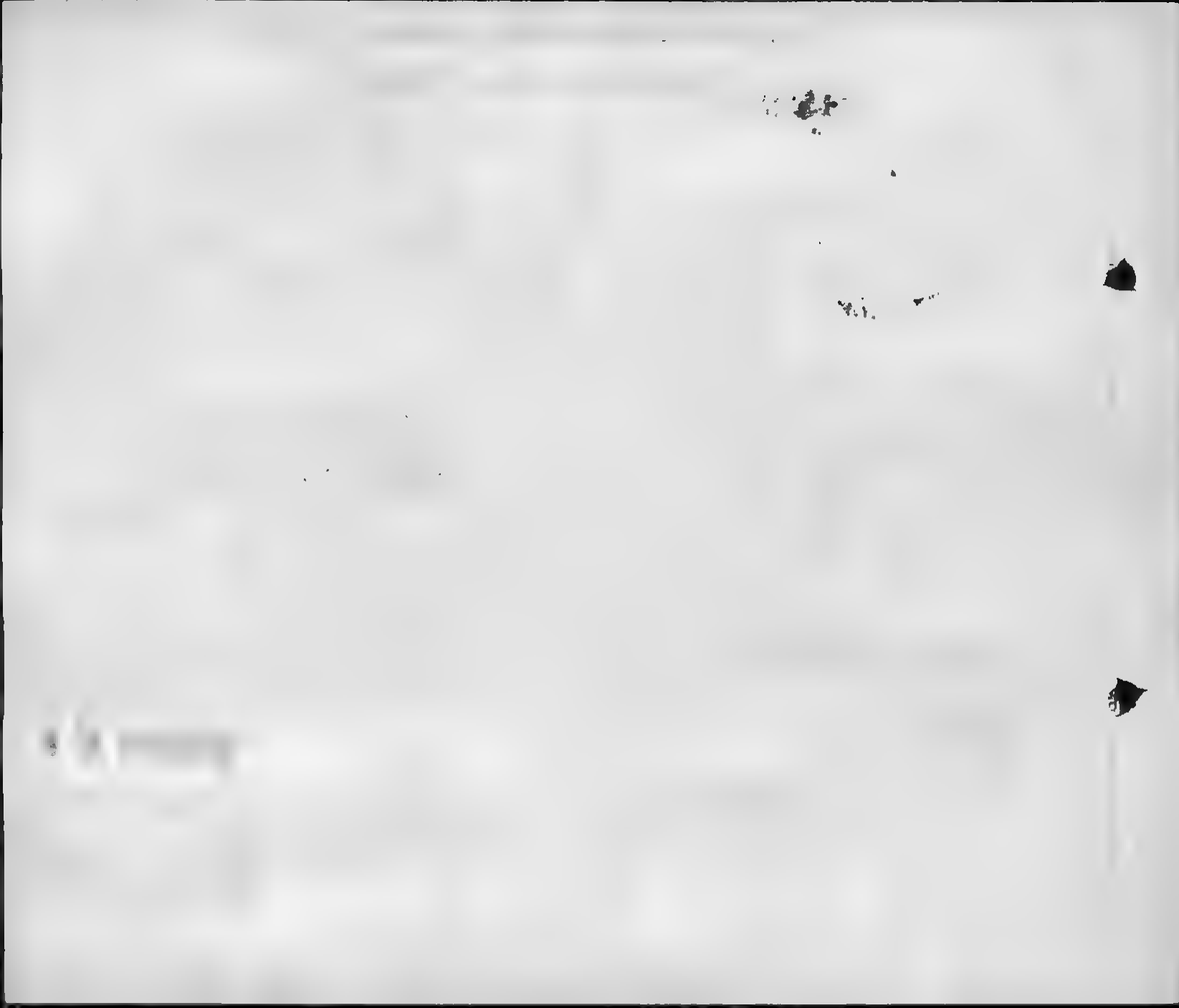
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>12 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>				STREET ADDRESS (If rural give location) <u>Francis Scott Key Hotel</u>			
3. NAME OF DECEASED (Type or Print) <u>Marj Bowers Maynard</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Dec. 15, 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Thomas Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Markwood Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frank R. Smith Jr. Cockeysville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION							
I. IMMEDIATE CAUSE (A) <u>Gornary Occulsion</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 4</u> ....., 19 <u>49</u> ....., to <u>Feb. 6</u> ....., 19 <u>56</u> ....., that I last saw the deceased alive on <u>Feb. 6</u> ....., 19 <u>56</u> ....., and that death occurred at <u>9:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Hies</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md.</u>		DATE SIGNED <u>2/7/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
24. REC'D BY REGISTRAR <u>Frank Smith</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u>		ADDRESS <u>1215 So. Paul St.</u>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1528 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

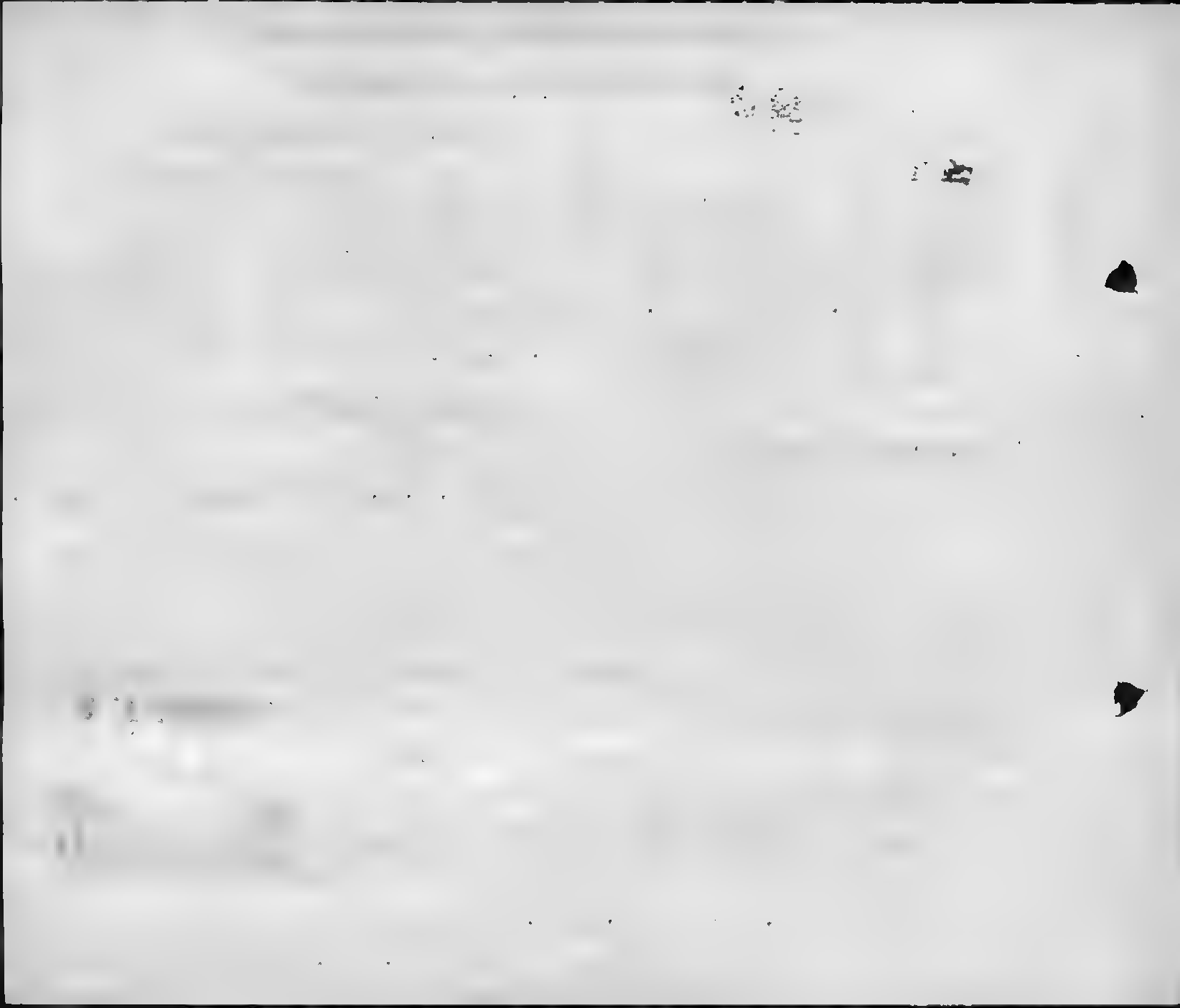
<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rodgers Forge</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rodgers Forge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>245 Rodgers Forge Road</u>				STREET ADDRESS (If rural give location) <u>245 Rodgers Forge Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mrs. Marie S. Mc Call</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>February 1st 19 56</u>			
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 26, 1893</u>		9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Mr. Charles Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Gloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT & ADDRESS <u>Mr. E. J. Mc Call, 245 Rodgers Forge Rd.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				<u>10 years after onset</u>		<u>sudden</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>on arteriosclerosis 3 years</u>				<u>8 years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>2. Diabetes (sugar) 10 years</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 25, 1956</u> <b>to</b> <u>Feb 1, 1956</u> <b>that I last saw the deceased</b> <b>alive on</b> <u>Jan 21, 1956</u> <b>and that death occurred at</b> <u>2:45 P.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Leonard J. Ruck</u> <b>ADDRESS (Street, city, town, state)</b> <u>5305 Harford Road #14</u> <b>DATE SIGNED</b> <u>Feb 1, 1956</u> <u>M.D.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 4th 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Marian Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Leonard J. Ruck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>			
DATE							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1 55 10M



MARYLAND

01479  
STATE DEPARTMENT OF HEALTH

1379

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Kingsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kingsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hilltop Drive		STREET ADDRESS (If rural, give location) Hilltop Drive	
3. NAME OF DECEASED (First) Mrs. Mamie (Middle) L. (Last) Mc Cann		4. DATE OF DEATH (Month) February (Day) 18th (Year) 1956	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Nov. 26, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 79 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Howard Streett		14. MOTHER'S MAIDEN NAME Jane Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Mildred Roeder, Hilltop Dr. Kingsville			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X Immediate cause (a) Congestive Heart Failure			3 hrs.
Antecedent cause(s) (b) Hypertensive Cardiovascular Disease			10 yrs. +
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 1, 1955, to Feb. 18, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 2:00 a.m., from the causes and on the date stated above.			
SIGNATURE William G. Tyson, M.D.		ADDRESS Kingsville Md. DATE SIGNED Feb. 18, 1956	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Feb. 21, 1956	
NAME OF CEMETERY OR CREMATORY Waters Memorial Cemetery		LOCATION (City, town, or county) Cooptown, Maryland (State)	
DATE REC'D BY LOCAL REG. Feb 20, 1956		REGISTRAR'S SIGNATURE H. H. Hedrick	
24. FUNERAL DIRECTOR		ADDRESS Leonard J. Ruck, 5305 Harford Road #14	

Dr. Tyson  
Kingsville, Md.  
Belair Rd. at main intersection.



## 1510 CERTIFICATE OF DEATH

Reg. Dist. No. 49

## 1. PLACE OF DEATH.

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL) LENGTH OF STAY  
OR (and give nearest town) (in this place)

TOWN FORT HOWARD 13 Days

HOSPITAL OR

INSTITUTION OR

STREET ADDRESS

VETERANS ADMINISTRATION HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE MARYLAND COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR  
TOWN BALTIMORE

STREET ADDRESS (If rural give location)

1800 NORTH CALVERT STREET

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JOHN

O.

MC CRACKEN

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

FEBRUARY 15

1956

## 5. SEX

6. COLOR OR RACE:

7. SINGLE

MARRIED

## 8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MALE

WHITE

WIDOWED, DIVORCED.

(Specify) MARRIED

March 18, 1895

60

Yrs

Months

Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).

Operator

10B. KIND OF BUSINESS OR INDUSTRY.

Motion Pictures

11. BIRTHPLACE (State or foreign country).

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME.

George McCracken

## 14. MOTHER'S MAIDEN NAME:

Dora Reinich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Yes

WW I

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT &amp; ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

(A) CARCINOMA OF LARYNX

## ANTECEDENT CAUSE (B):

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

HYPERTENSIVE CARDIOVASCULAR DISEASE

## INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

UNKNOWN

## 19A. DATE OF OPERATION.

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2, 1956, to Feb. 15, 1956

and that death occurred at 2:05 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

F. G. Dickey, M.D., Chief, Medical Service

M. D. VAH, FORT HOWARD, MARYLAND 2-15-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

2-17-56

Baltimore National Cemetery Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

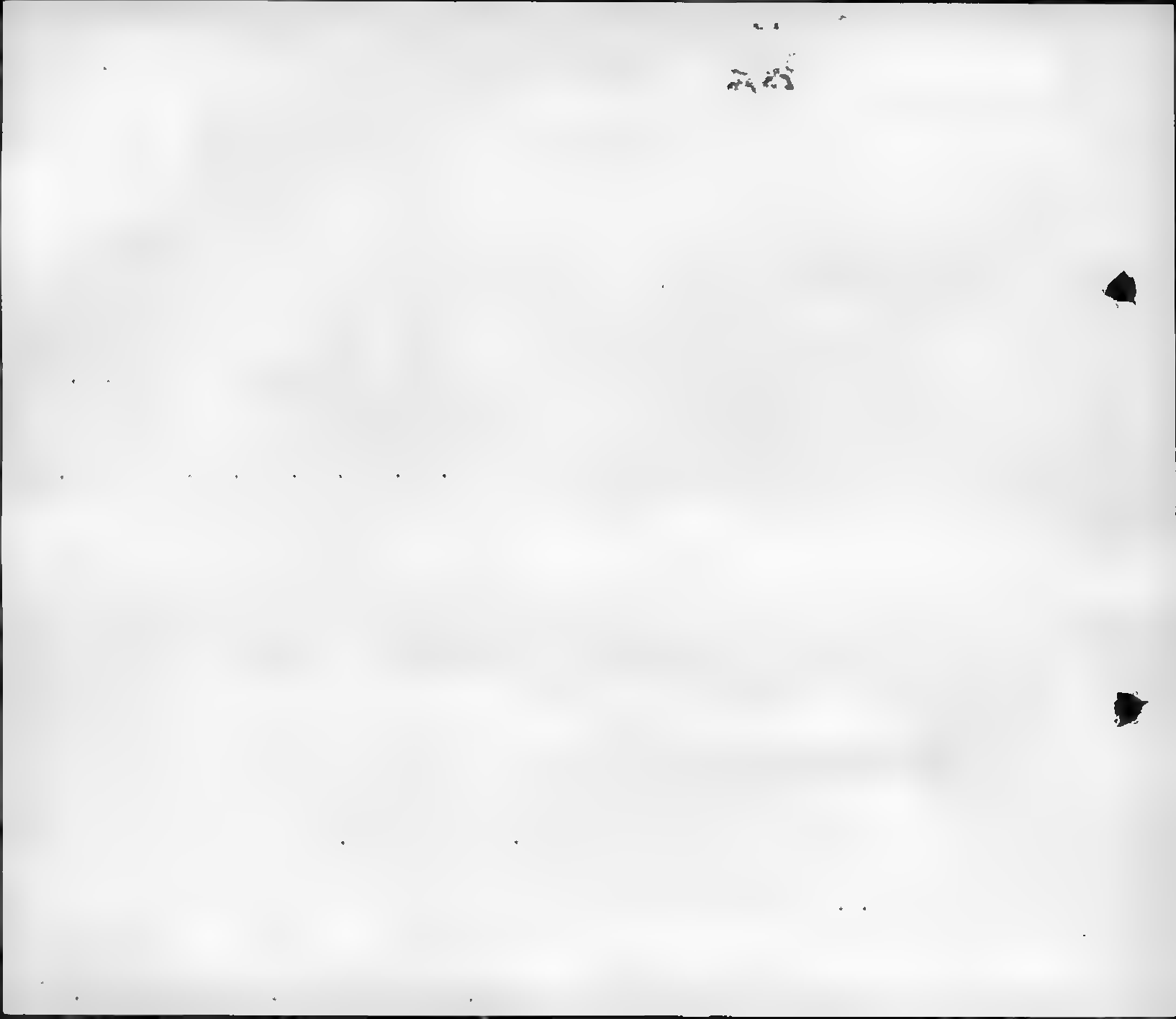
## 24. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Blight, Inc., 6009 Harford Rd. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01481  
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>522 Windwood Road</b>				d. STREET ADDRESS <b>522 Windwood Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mr. Dwight I. Mc Kay</b>				4. DATE OF DEATH Month Day Year <b>February 27th 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 25, 1887</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Emp. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Albert L. Mc Kay</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Mc Arthur</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Charles Robinson, 522 Windwood Road.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysemia</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic bronchitis and asthma</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Danbury, Connecticut</b>	(State)			
21. I certify that I attended the deceased from <b>2-22</b> , 1952, to <b>2-27</b> , 1956, that I last saw the deceased alive on <b>2-27-56</b> , and that death occurred at <b>10:34 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William C. Helfrich, M.D. 5006 Roland Ave, Balt. 10 Md</b>							
ACTUAL SIGNATURE <b>William C. Helfrich</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William C. Helfrich, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 1, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brookfield Central Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Danbury, Connecticut</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>				24a. RECEIVED BY REGISTRAR DATE <b>Feb. 29, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

2014



RECEIVED

1956

RECEIVED

## 1512 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Calvert</b>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Catonsville</b>		LENGTH OF STAY (in this place) <b>4 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Mt. Wilson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hospital</b>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <b>George</b> (Middle) <b>W.</b> (Last) <b>Monnett</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Feb. 25</b> 19 <b>56</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>Jan. 5, 1880</b>	9. AGE last birthday <b>76</b> yrs.	10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Odd Jobs</b>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>Charles Monnett</b>				14. MOTHER'S MAIDEN NAME: <b>Catherine Boyd</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>Records: Spring Grove State Hospital</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		(A) <b>Acute myocardial infarction</b>				<b>4 hours</b>	
ANTECEDENT CAUSE (B)		(B) <b>Arteriosclerotic coronary thrombosis</b>				<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <b>Generalized arteriosclerosis</b>				<b>years</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>2</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2-15-56</b> to <b>2-25-56</b> , what I last saw the deceased alive on <b>2-25-56</b> , 1956, and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Harold E. Edlerhouse</b>		ADDRESS <b>M.D. Spring Grove Hospital</b>		DATE SIGNED <b>2-25-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		DATE THEREOF <b>Feb. 28, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>SPRING GROVE STATE HOSP.</b>		LOCATION (City, town, or county) (State) <b>Catonsville 28, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2/28/56</b>		REGISTRAR'S SIGNATURE <b>T.E. [Signature]</b>		24. FUNERAL DIRECTOR ADDRESS <b>SPRING GROVE STATE HOSPITAL - Catonsville 28, Maryland</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 29 1956

BUREAU V. S.

## 1513 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
OR TOWN <u>Catonsville</u>				OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Coton Ridge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>2568-W. Fairmount Ave.</u>			
3. NAME OF DECEASED: (First) <u>Hattie</u> (Middle) <u>-</u> (Last) <u>MEYER</u>				4. DATE OF DEATH: (Month) <u>Feb</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed Aug. 3, 1876</u>		8. DATE OF BIRTH: <u>79</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, (en if retired): <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY: <u>USA</u>							
13. FATHER'S NAME: <u>? Ward.</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No: <u>?</u>			
17. INFORMANT'S ADDRESS: <u>Hannie Smith - 2568-W. Fairmount Ave.</u>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Broncho pneumonia</u>							
Antecedent causes (s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <u>Chronic sclerotic 2) Ascending pancreas</u>							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1953, to Feb. 2, 1956, that I last saw the deceased alive on Feb. 2, 1956, and that death occurred at 10:30 PM from the causes and on the date stated above.							
SIGNATURE <u>W. H. Rouse</u> (Degree or title)				ADDRESS <u>4605 Edgewood Ave. 2/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>Feb. 6, 1956</u> NAME OF CEMETERY OR CREMATOR <u>London Park Cem. Baltimore, Md.</u> LOCATION (City, town, or county) (State)							
DATE RECD BY LOCAL REGISTRAR <u>2/6/56</u>				REGISTRAR'S SIGNATURE <u>A. H. Hedrich</u>			
				FEDERAL DIRECTOR'S ADDRESS <u>H. B. Hyatt: 1300 Eutaw Place</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

01484

1514

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Baltimore</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spring Grove State Hosp.</b>		STREET ADDRESS (If rural, give location) <b>480 Sanders St.</b>	
3. NAME OF DECEASED (Type or Print) (First) <b>Raymond</b> (Middle) <b>P.</b> (Last) <b>Michael</b>		4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>17,</b> (Year) <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Apr 15 '98</b>
9. AGE last birthday <b>57</b> yrs.		10. UNDER 1 year Months <b>57</b> Days	11. UNDER 24 hrs. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merch Marine</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>V. William Michael</b>		14. MOTHER'S MAIDEN NAME <b>Mrs Margaret Marburger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT AND ADDRESS <b>Records; Spring Grove State Hospital</b>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Congestive heart failure**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Regurgitated feed in bronchus**

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

**Tumor fourth ventricle**

?

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY **Hospital**(CITY OR TOWN)  
**Catonsville**(COUNTY)  
**Baltimore**

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY **2/17/56 4:30 pm.**INJURY OCCURRED  
While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

**Regurgitated feed during meal**

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL

REGISTRAR'S SIGNATURE

**Louden Park Cem.**

24. FUNERAL DIRECTOR

**Baltimore, Md.**

ADDRESS

**Feb 20/56 G. W. Hedgcock M. J. Lickner & Sons - Balt**  
**17, Md**

100



1515

## CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto Co md</u>	LENGTH OF STAY (in this place) <u>50 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto Co md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4306 Kenwood Ave</u>		STREET ADDRESS (If rural give location) <u>4306 Kenwood Ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>Auguste S. Micklich</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb 3 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Oct 2-1970</u>
9. AGE last birthday <u>85 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Conrad Fischer</u>	
14. MOTHER'S MAIDEN NAME: <u>Johanna Vager</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY No. <u>NO</u>		17. INFORMANT & ADDRESS: <u>Mr Karl Gabel 2605 Brandon Ave</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>			<u>2 hours</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular Disease.</u>			<u>many yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June, 1947</u> , to <u>Feb 3, 1956</u> , that I last saw the deceased alive on <u>Feb 2, 1956</u> , and that death occurred at <u>9:35 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>May R. English</u>		DATE SIGNED <u>2-6-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/7/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cen</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
24. FUNERAL DIRECTOR <u>Reifenfeld</u>		ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr English.

11.11

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11.11.11

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1516

## CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>		<u>30 days</u>		TOWN <u>BALTIMORE</u>		<u>3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in The Pines</u>				STREET ADDRESS (If rural give location) <u>605 MONASTERY AVE.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY C. MILLER</u>				<u>Feb. 27 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>AUG. 17, 1906</u>	<u>49</u> yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>HOUSE WIFE</u>					<u>BALTO. MARYLAND</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM M. MILLER</u>				<u>AMANDA ELEN Mc COMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>219-07-1712</u>		<u>MR. E. P. MILLER 605 MONASTERY AVE. (29)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A)						<u>General Carcinomatosis</u>	
2. ANTECEDENT CAUSE(S) DUE TO						<u>Carcinoma of Rectum</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>9 1/2 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/19</u> <u>1956</u> to <u>2/27</u> <u>1956</u> , that I last saw the deceased alive on <u>2/25</u> <u>1956</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the data stated above.							
SIGNATURE <u>E. L. W. Schumacher</u>				ADDRESS (Street, city, town, state) <u>3432 Oakwood Ave. BALTO. MARYLAND</u>		DATE SIGNED <u>2/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/1/56</u>		<u>LONGRAVE PARK CEM.</u>		<u>BALTO. MARYLAND</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB</u>		<u>E. E. Harvey</u>		<u>E. L. W. Schumacher</u>		<u>3512 Frederick Ave. (29)</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

UNITED V. S.

FEB 20 1961

RECEIVED

01487

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1517

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New York</u> COUNTY <u>N. Y.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>35 Marion St. Brooklyn</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>Henry</u> (Last) <u>Miller</u>	4. DATE OF DEATH (Month) <u>2</u> (Day) <u>8</u> (Year) <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>10/21/1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Binding</u>	9. AGE last birthday <u>38</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Durham N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fred Miller</u>		14. MOTHER'S MAIDEN NAME <u>Vallie Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.F.</u>		16. SOCIAL SECURITY NO. <u>242-30-6375</u>	
17. INFORMANT AND ADDRESS <u>Cardell Miller 35 Marion St. Brooklyn</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Fracture of Skull 24 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Auto Accident

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 Mins

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>Suicide</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10/21/1914</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>at 6:30 AM</u>	
22. I hereby certify that I <u>inspected</u> the deceased <u>24-52</u> at <u>6:30</u> on <u>10/21/58</u> that I last saw the deceased <u>alive on</u> <u>10/21/58</u> , and that death occurred at <u>6:30</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Dr. H. E. Miller, M.D. Rep. Med. Examiner</u>		(Degree or title)		ADDRESS <u>2145 Chesapeake Blvd. Balt 22</u>	
DATE SIGNED <u>2-9-58</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREON <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Long Island National Cem. Long Island N.Y.</u>	
DATE RECD BY LOCAL REG. <u>1/7/56</u>		REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Holland Funeral Home</u>	
				ADDRESS <u>1631 David Hill Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

100





1518

## CERTIFICATE OF DEATH

Reg. Dist. No.

35

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>		c. LENGTH OF STAY IN 1b <b>25 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hunters Mill Rd.</b>		d. STREET ADDRESS <b>Hunters Mill Rd.</b>	
3 NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Powell Molock</b>		4. DATE OF DEATH Month <b>2-28-56</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-1879</b>
9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>	IF UNDER 24 HRS Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac</b>		14. MOTHER'S MAIDEN NAME <b>Laura ??</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Howard Molock, White Hall Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>50</b> , 19 <b>50</b> , to <b>Feb 28</b> , 19 <b>56</b> that I last saw the deceased alive on <b>Feb 23</b> , 19 <b>56</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter Bortner</b> M.D.		ADDRESS (Street, city or town, state) <b>White Hall Md</b> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-3-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stephenson A.M.E.</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>		ADDRESS <b>Sparks, Md.</b>	24a. REC'D BY REGISTRAR <b>DATE 3-6-56</b>
		24b. REGISTRAR'S SIGNATURE <b>Annalee W. Markline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD A. S.

17

17

## 1519 CERTIFICATE OF DEATH

Reg. Dist. No. ....

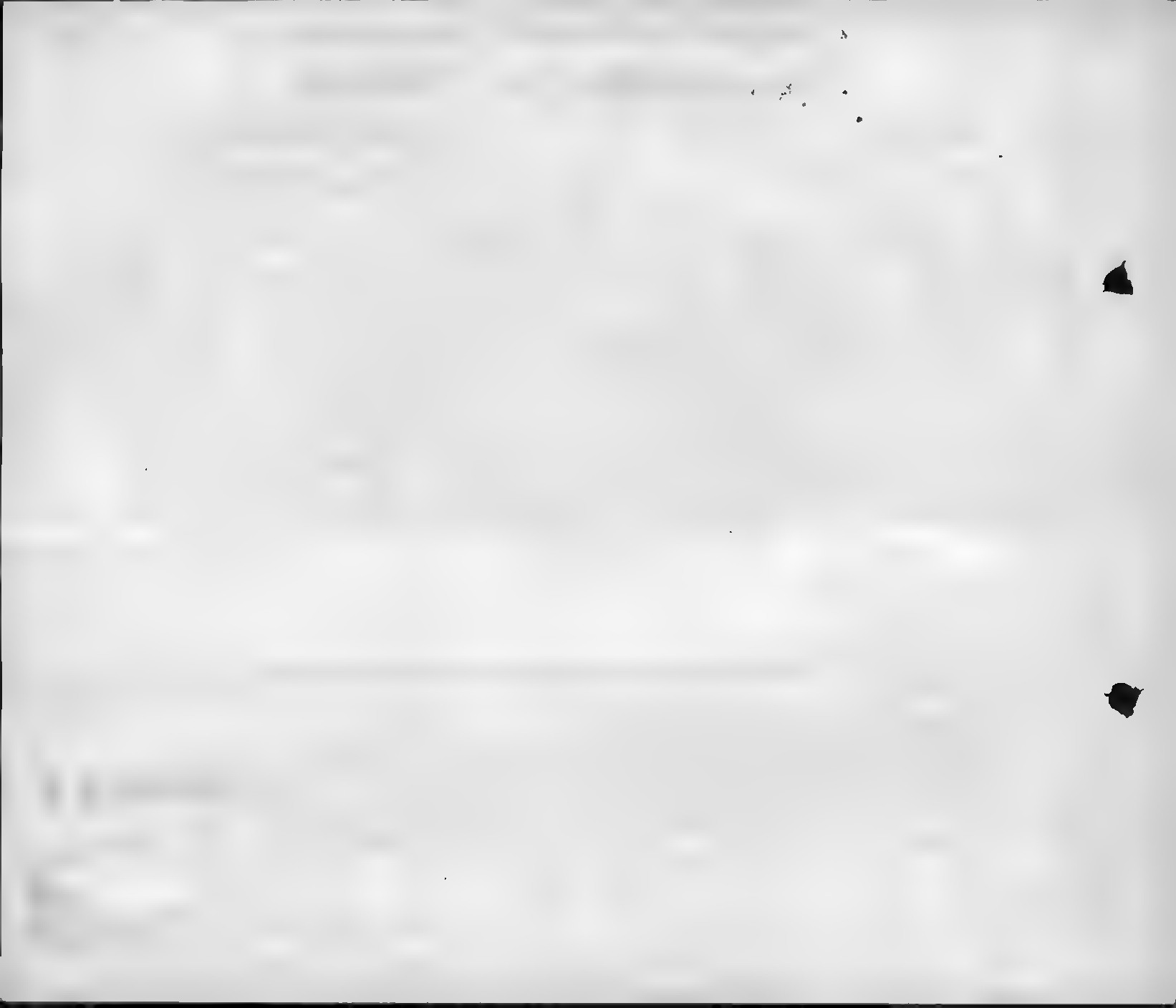
1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>DALTO.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u>	LENGTH OF STAY (in this place) <u>4 YRS.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8411 LOCH RAVEN BLVD.</u>		STREET ADDRESS (If rural, give location) <u>8411 LOCH RAVEN BLVD.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSE (First) ALBERT MUELLER (Middle) (Last)</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-6-1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV. 22, 1879</u>
9. AGE last birthday <u>76</u> yrs.		10. # UNDER 1 YEAR Months Days 11. # UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANCIS ALBERT</u>		14. MOTHER'S MAIDEN NAME <u>MADELINE WHISTLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MRS WM. A. BOWLING 8411 LOCH RAVEN BLVD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis.</u>			
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOFSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/6/56</u> , 19 <u>56</u> , to <u>2/7/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/6/56</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Denis J. McGrath</u>		DATE SIGNED <u>2/7/56</u>	
ADDRESS (Street, city, town, state) <u>8358 Loch Raven Rd. MD</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>2/8/56</u>	NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
24. REC'D BY REGISTRAR <u>1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Jenkins</u> ADDRESS <u>4905 YORK RD.</u>	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



## CERTIFICATE OF DEATH

Reg. Dist. No.....

1520

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Riderwood Md</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sorenson Nursing Home</i>				STREET ADDRESS (If rural, give location) <i>537 N 17th St</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>ELIZABETH R. Murphy</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>Feb 7 1956</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow Dec</i>		8. DATE OF BIRTH: <i>1876 79</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <i>79</i> yrs.		11. BIRTHPLACE (State or foreign country): <i>Md.</i>	
13. FATHER'S NAME: <i>Patrick Doyle</i>				14. MOTHER'S MAIDEN NAME: <i>Bridget Kiernan</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <i>-</i>			
				17. INFORMANT & ADDRESS: <i>Catherine Elliott 5304 Barbara St.</i>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a)..... DUE TO					
Antecedent cause(s) (b)..... DUE TO					
(c).....					
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.					
SIGNATURE <i>E. Ellworth Cook</i>		(DEGREE OR TITLE) <i>M.D.</i>		ADDRESS <i>421 Maryland Avenue</i>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF <i>2-10-56</i>		NAME OF CEMETERY OR CREMATORY <i>Cathedral Cem</i>	
LOCATION (City, town, or county) (State) <i>Baltimore City Md</i>		24. FUNERAL DIRECTOR		ADDRESS <i>Frank W. Seitz R14W 36th St</i>	
DATE REC'D BY LOCAL REG <i>Feb 8, 1956</i>		REGISTRAR'S SIGNATURE <i>A. W. Hedrick</i>			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1894



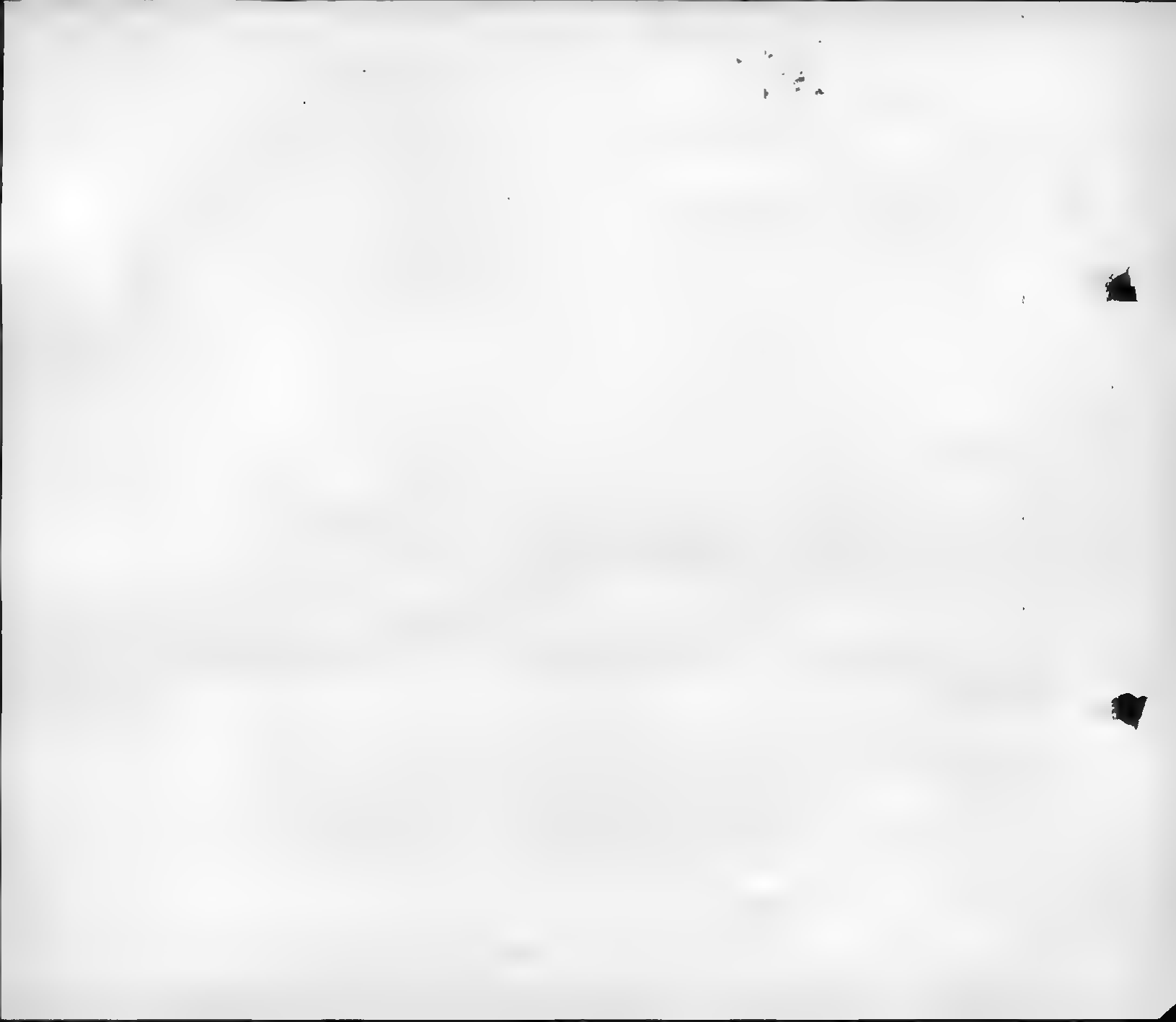
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01491

## 1521 CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> COUNTY <u>Balto.</u> MARYLAND CITY <u>Swynn Oak</u> (If outside corporate limits, write RURAL) LENGTH OF STAY <u>17 yrs.</u> OR <u>Swynn Oak</u> (in this place) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegsbury Home</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville Balto Co.</u> OR TOWN STREET ADDRESS <u>Lutherville Balto Co.</u> (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Georgiana</u> (First) (Middle) (Last) <u>Musgrove</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2</u> <u>19</u> <u>1956</u>	
<b>5. SEX</b> <u>F.</u> <b>6. COLOR OR RACE</b> <u>W.</u> <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> <u>Divorced</u> <b>8. DATE OF BIRTH</b> <u>2/8/1860</u> <b>9. AGE</b> (last birthday) <u>96</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		<b>11. PLACE OF BIRTH</b> (State or foreign country) <u>Balto</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Chestnut Ridge Co.</u> <b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>13. FATHER'S NAME</b> <u>Geo Todd</u> <b>14. MOTHER'S MARDEN NAME</b> <u>Jane Mayer</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>—</u> <b>16. SOCIAL SECURITY NO.</b> (If Yes, give war or dates of service) <u>—</u> <b>17. INFORMANT &amp; ADDRESS</b> <u>Records Allegsbury Home</u>		<b>18. MEDICAL CERTIFICATION</b> <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> IMMEDIATE CAUSE (A) <u>Arterio - Sclerotic - Heart</u> ANTECEDENT CAUSE (B) <u>Diseases - c. Arterio</u> DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>7. Irritating</u> <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b> <u>Generalized Arterio - Sclerosis</u>	
<b>19A. DATE OF OPERATION</b> <u>10/7</u> <b>19B. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY</b> <u>—</u> <b>21C. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>21D. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <u>—</u> <b>21E. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>10/7</u> <u>1950</u> <b>to</b> <u>Feb. 79, 1956</u> <b>that I last saw the deceased</b> <u>alive on Feb. 16, 1956, and that death occurred at</u> <u>M. from the causes and on the date stated above.</u> SIGNATURE <u>Paul L. Chambers</u> ADDRESS <u>4108 Liberty Hts. Baltimore</u> DATE SIGNED <u>2-13/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>DATE THEREOF</b> <u>2/22/56</u> <b>NAME OF CEMETERY OR CREMATORY</b> <u>Carroll Mt.</u> <b>LOCATION</b> (City, town, or county) <u>Balto Co.</u>		<b>24. FUNERAL DIRECTOR</b> <u>Paul L. Deemann</u> <b>ADDRESS</b> <u>6067 Harford Rd.</u>	
<b>DATE REC'D BY LOCAL REGISTRAR</b> <u>Feb 21/1956</u> <b>REGISTRAR'S SIGNATURE</b> <u>Ed. H. H. H.</u>		<b>24. FUNERAL DIRECTOR</b> <u>Paul L. Deemann</u> <b>ADDRESS</b> <u>6067 Harford Rd.</u>	





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01492

## 1522 CERTIFICATE OF DEATH

Reg. Dist. No. 35

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural--White Hall</u>		LENGTH OF STAY (in this place) <u>1 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural--White Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>JUDITH A. PARDEW</u>				<u>FEB. 13, 1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>Wh.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Wid.</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 12, 1868</u>		<b>9. AGE last birthday</b> <u>87 yrs.</u>	<b>IF UNDER 1 YEAR</b> (Month) (Day) (Year) <u>IF UNDER 24 HRS (Hours) (Min.)</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Home (Housewife)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Elliott Welborn</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Nancy Snow</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>W.E. Pardew, White Hall, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Lupus erythematosus</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan. 31, 1956</u> , <b>to</b> <u>Feb. 13, 1956</u> , <b>that I last saw the deceased alive on</b> <u>2-12-56</u> , <b>and that death occurred at</b> <u>10 a.m.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Willard P. Hudson</u> M.D. Forest Hill, Md.				<b>DATE SIGNED</b> <u>2-14-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. 17, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>State Road</u>		<b>LOCATION (City, town, or county)</b> <u>State Road, Surry, N.C.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Howard S. Markley</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>			
<b>DATE</b> <u>2-16-56</u>							

10/1/50

1523

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Monkton</i>		LENGTH OF STAY (in this place) <i>64 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Monkton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Carroll Road</i>				STREET ADDRESS (If rural give location) <i>Carroll Road</i>			
3. NAME OF DECEASED (Type or Print) <i>Estelle Hutchins Pearce</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Feb 5 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>5 December 1870</i>	9. AGE last birthday <i>85</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Taylor Balto Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Slade Hutchins</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane Hawkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT & ADDRESS <i>Jacob M. Pearce Monkton, Md</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardiac Decompensation</i>						<i>2 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio-sclerotic cardiovascular disease</i>						<i>OVER 5 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1950</i> , to <i>Feb</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3 Feb</i> , 19 <i>56</i> , and that death occurred at <i>11 A</i> . M, from the causes and on the date stated above.							
SIGNATURE <i>Walter L. Coe</i>		M.D. <i>Cockeysville</i>		ADDRESS (Street, city, town, state)		DATE SIGNED <i>5 Feb. 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Feb 7-1956</i>	NAME OF CEMETERY OR CREMATORY <i>St. James</i>		LOCATION (City, town, or county) (State) <i>Monkton Md.</i>			
24. REC'D BY REGISTRAR DATE <i>2-8-56</i>	REGISTRAR'S SIGNATURE <i>Mrs Howard S. Markline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Martin G. Kutz</i>		ADDRESS <i>Jarvisville</i>		

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

18 1911

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01494

1524

## CERTIFICATE OF DEATH

Reg. Dist. No. 50

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>67 yrs.</u>		TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1937 Frederick Road</u>				STREET ADDRESS (If rural give location) <u>1937 Frederick Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIAM R. H. PEEPLES</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb. 25, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 4, 1880</u>	
9. AGE last birthday <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Joseph Peeples</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-20-4178</u>		17. INFORMANT & ADDRESS <u>Catonsville - 28, Md.</u>		<u>Mrs. Anna K. Peeples 1937 Fred. Rd.</u>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>				<u>6 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Ch. Hypertensive Cardio Vascular Disease</u>				<u>12 yrs</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-6</u> , 19 <u>43</u> , to <u>2-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-24</u> , 19 <u>56</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wilmer K. Gallager</u>				ADDRESS (Street, city, town, state) <u>M.D. 6209 Frederick Ave. Balt 28, Md.</u>			
DATE SIGNED <u>2-27-56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/28/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cem.</u>		LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>2/27/56</u>		REGISTRAR'S SIGNATURE <u>T. E. Hertzog</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Williams</u>		ADDRESS <u>Catonsville, Md.</u>	

RECEIVED

FEB 23 1958

U.S. DEPARTMENT OF JUSTICE

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01495

## 1525 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Loch Raven (Phoenix PO)</u>		<u>Life</u>		TOWN <u>Loch Raven (Phoenix P.O.)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dulaney Valley Road</u>				STREET ADDRESS (If rural give location) <u>Dulaney Valley Road</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM EDWARD PEERCE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 7, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>March, 1880</u>	
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward S. Pearce</u>				14. MOTHER'S MAIDEN NAME <u>Laura Pearce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Family Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>carcinoma of the lung</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home - no accident</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11/23/56</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>X</u>			
22. I hereby certify that I attended the deceased from <u>11/23/56</u> , 19....., to <u>2/7/56</u> , 19....., that I last saw the deceased alive on <u>1/7/56</u> , 19....., and that death occurred at <u>9:33 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>-1205 N. Calvert St.</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Cemetery</u>		LOCATION (City, town, or county) (State) <u>Long Green, Balto. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Towson, Maryland</u>	
DATE <u>2-10-1956</u>							





## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

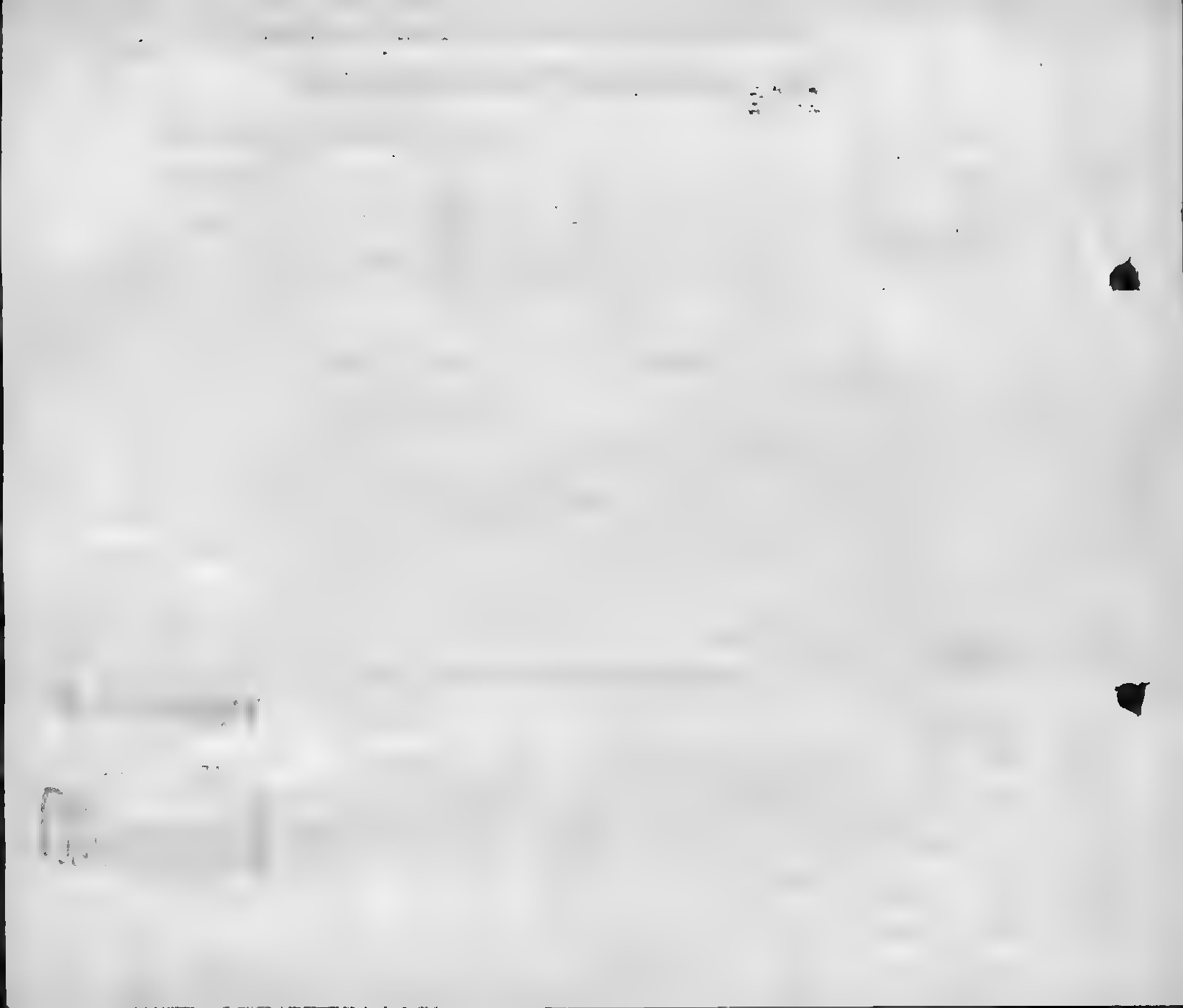
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01496

## 1526 CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTO. CO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (If this place) <u>8 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WAKNE CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>9 HARBOR RD. BAYSIDE</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MARGARET K. PEPPLER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2/13/56</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOW</u>	<b>8. DATE OF BIRTH</b> <u>3/20/86</u>	<b>9. AGE last birthday</b> <u>69</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, or if retired) <u>Domestic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Frederick Bauer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Kahn</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Raymond J. Harris</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C.V.D.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct 13, 1956</u> <b>to</b> <u>Feb 13, 1956</u> <b>that I last saw the deceased alive on</b> <u>Feb 13, 1956</u> <b>and that death occurred at</b> <u>8:15</u> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>J. J. Harris M.D.</u>				<b>DATE SIGNED</b> <u>2/13/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>2/16/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Gorraine</u>		<b>LOCATION (City, town, or county)</b> <u>Balto. Co.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>U.E. Harry</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Mac Nabbs &amp; Son</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>2-16-56</u>							



## 1527 CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH.

COUNTY BALTIMORE MARYLAND  
CITY (If outside corporate limits, write RURAL and give nearest town)  
OR TOWN FORT HOWARD LENGTH OF STAY 20 Hours  
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY  
CITY (If outside corporate limits, write RURAL and give nearest town)  
OR TOWN BALTIMORE  
STREET ADDRESS (If rural give location) 7935 DELROSE AVENUE

3 NAME OF DECEASED: (First) (Middle) (Last)  
WILLIAM C. PFELFFER

4. DATE (Month) (Day) (Year)  
OF DEATH FEBRUARY 16 19 56

5 SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single 8. DATE OF BIRTH: December 10, 1877

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 78

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Seaman 10B. KIND OF BUSINESS OR INDUSTRY: Banana Boat

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13 FATHER'S NAME: Charles Pfeiffer

14 MOTHER'S MAIDEN NAME: Minnie Bartz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) if Yes, give war or dates of service: Yes P. I.

16 SOCIAL SECURITY NO. 220-07-8762

17. INFORMANT &amp; ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.

(A) DIFFUSE MYOCARDIAL FIBROSIS WITH MURAL THROMBI, LEFT VENTRICLE  
(B) DUE TO CORONARY ARTERIOSCLEROSIS

DUE TO

## (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. LOBULAR PNEUMONIA

## INTERVAL BETWEEN ONSET AND DEATH

UNKNOWN

UNKNOWN

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While at work Not while at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 19 56 to Feb. 16, 19 56 and that death occurred at 7:30 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

D. D. MARK, M.D.

M. D. VAH, FORT HOWARD, MARYLAND

2-17-56

23 BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

2-20-56

Parkwood Cemetery Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24 FUNERAL DIRECTOR

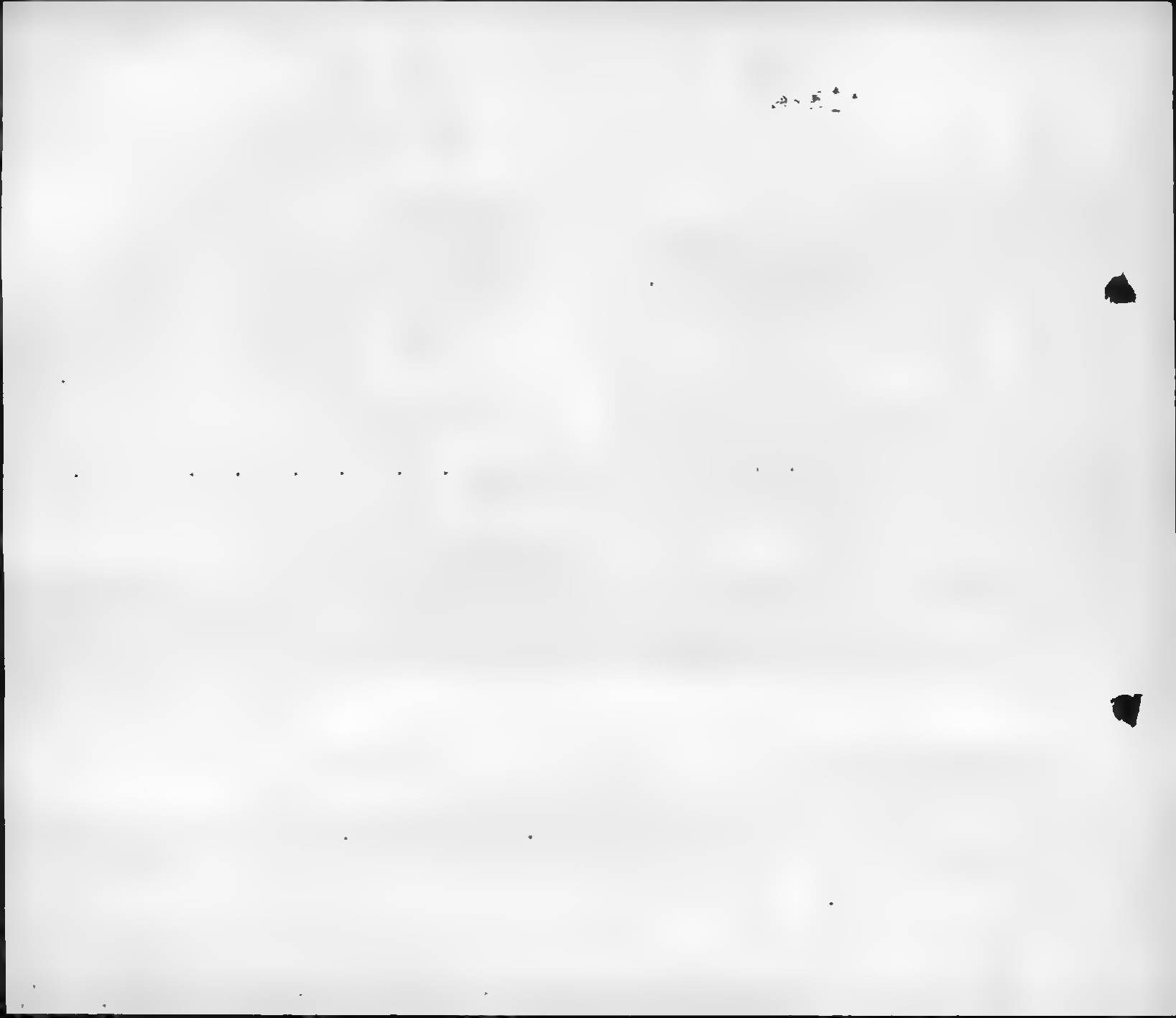
ADDRESS

Feb 20 1956

Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1528

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>59 Days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>2128 ORLEANS STREET</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <b>STANISLAW POLSKI</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>FEBRUARY 9 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE MARRIED W. DOWED DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>April 18, 1892</b>
		9. AGE last birthday <b>63</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Cemetery</b>	11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>
13. FATHER'S NAME: <b>Valanty Polski</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY No. <b>214-10-0191</b>	
17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <b>ADENOCARCINOMA, RECTUM</b>	DUE TO	<b>1 YEAR</b>
ANTECEDENT CAUSE (B)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <b>8/16/55</b>	19B. MAJOR FINDINGS OF OPERATION: <b>Transverse Colostomy</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------------	---------------------------------------------------------------	----------------------------------------------------------------------------------

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA</b>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 12, 1955**, to **Feb. 9, 1956**, and that I last saw the deceased **Dec. 12, 1955**, and that death occurred at **2:45 PM**, from the causes and on the date stated above.

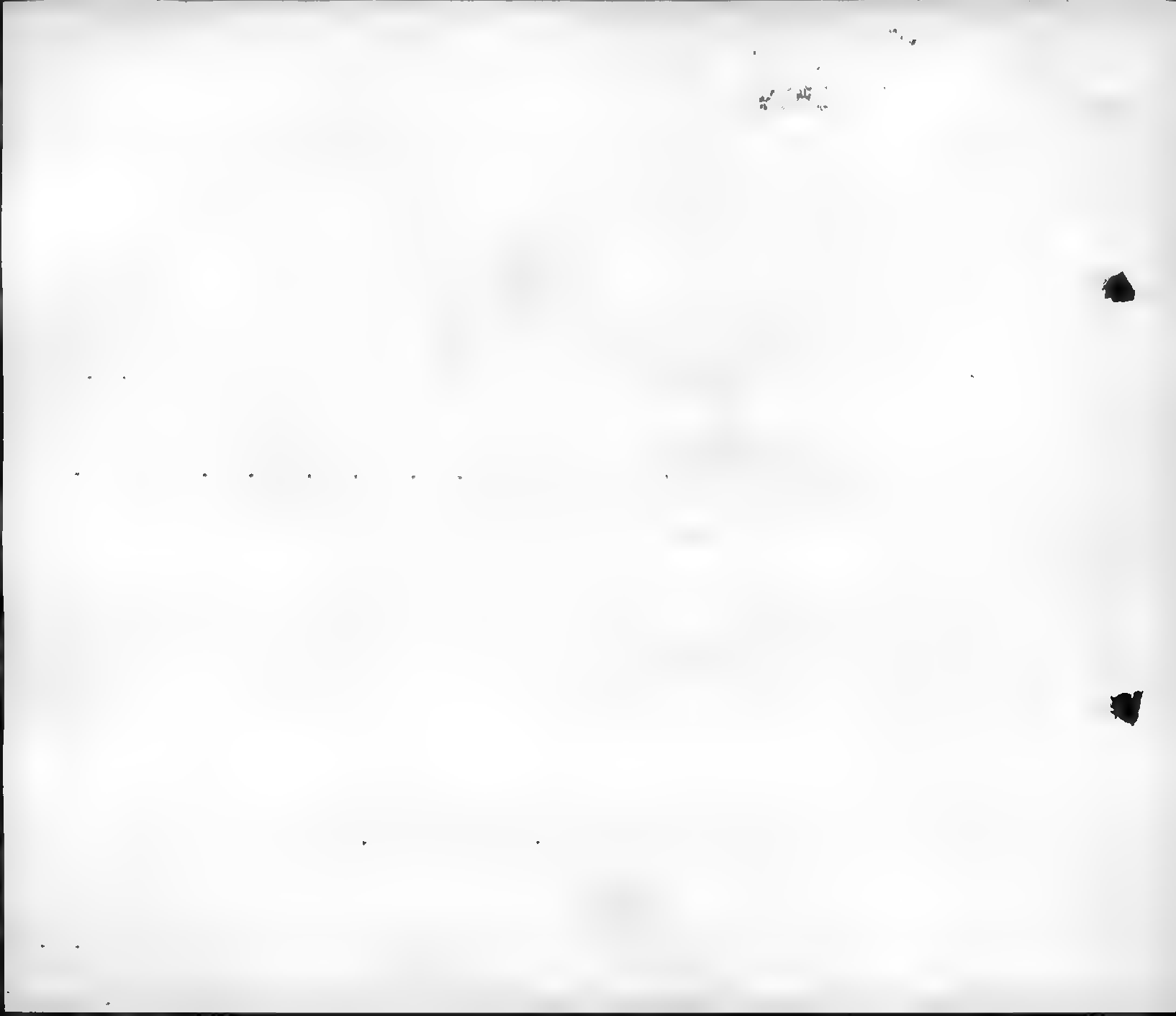
SIGNATURE <b>Irving Freeman</b>	ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b>	DATE SIGNED <b>2/9/56</b>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Feb 13, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>
LOCATION (City, town, or county) (State) <b>4430 Belair Road, Balto. Md.</b>		

DATE REC'D BY LOCAL REGISTRAR <b>February 11, 1956</b>	REGISTRAR'S SIGNATURE <b>R.W.</b>	24. FUNERAL DIRECTOR ADDRESS <b>Lilly &amp; Zeilen Inc., Fun. Dir 1901 Eastern Av. Balto. Md.</b>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01499

1529

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (In this place) <u>2 MO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>28 MELROSE AVE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOUSE IN PINES</u>				STREET ADDRESS (If rural give location) <u>CATONSVILLE</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MABEL A. PORTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2-8-56</u> 19 <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3/10/1850</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clean</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>office</u>		11. BIRTHPLACE (State or foreign country) <u>Me.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Porter</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Hosp. records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 da.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Decompensation</u>						<u>3 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Rheumatic Heart Disease</u>						<u>20 y (7)</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-18</u> , 19 <u>55</u> , to <u>2-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>56</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William K. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M.D. Catonsville-28, Md.</u>		DATE SIGNED <u>2-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR DATE <u>2/21/56</u>		REGISTRAR'S SIGNATURE <u>Thos. J. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>MacArthurson</u>		ADDRESS <u>28</u>	

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FEB

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MARYLAND STATE DEPARTMENT OF HEALTH

01501

1531 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Owens</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Balto Md</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6900 Belair Rd.</b>		STREET ADDRESS (If rural, give location) <b>6900 Belair Rd</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Bertha</b> (Middle) <b>Idella</b> (Last) <b>Punkte</b>	4. DATE OF DEATH (Month) <b>2</b> (Day) <b>18</b> (Year) <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <b>Feb 7, 1886</b>
9. AGE last birthday <b>70</b> yrs.		10. UNDER 24 hrs. Months Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm Du Val</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Jane Townsend</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT AND ADDRESS <b>Gertrude Punkte - 4129 Martin Ave.</b>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) ...	<b>Coronary Occlusion</b>	<b>5-10 min</b>
Antecedent cause(s) (b) ...	<b>Coronary Artery disease</b>	<b>Sev yrs.</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<b>Cardiac Failure - compensated</b>	<b>Sev yrs</b>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

SIGNATURE <b>John C. Kyle M.D.</b>	(Degree or title)	ADDRESS <b>7527 Belair Rd</b>	DATE SIGNED <b>2-16-56</b>
DATE OF EXAMINATION <b>Feb. 21, 1956</b>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <b>St. Charles N. C.</b>	LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>
DATE RECEIVED BY LOCAL REG. <b>Feb 19, 1956</b>	REGISTRAR'S SIGNATURE <b>Wm. H. T. Keifman</b>	23. FUNERAL DIRECTOR <b>Funeral Home - 7401 Belair Rd</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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/ 986

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

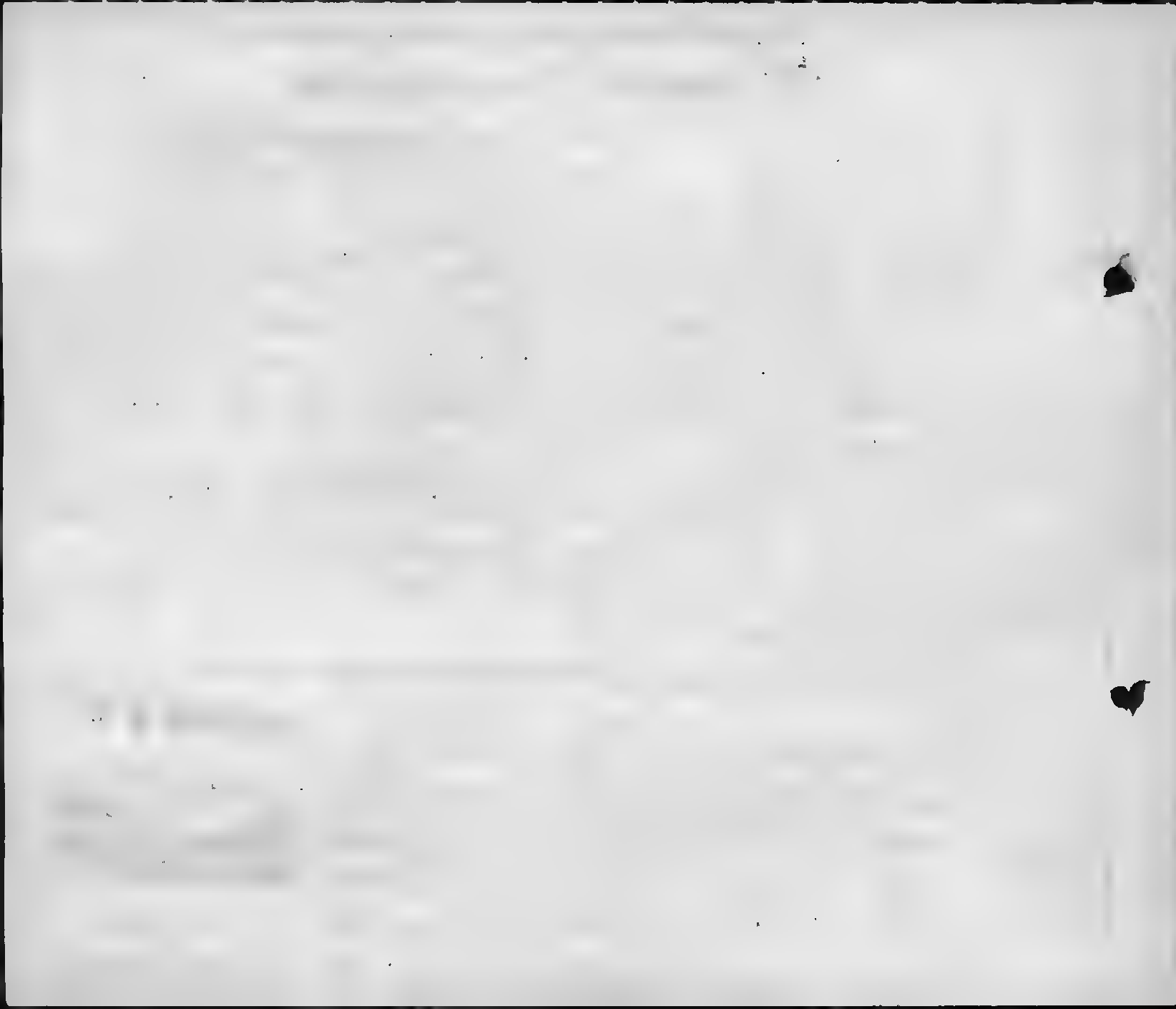
1532 **CERTIFICATE OF DEATH**

01502

Reg. Dist. No. ....

Item 12, Filr-G192 2-10-56 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Parkville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5743 Edmondson Avenue</b>				STREET ADDRESS (If rural give location) <b>8310 Harford Road #14</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Christian</b> (First) <b>Rau</b> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <b>February</b> (Day) <b>5th</b> (Year) <b>1956</b>			
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>	<b>8. DATE OF BIRTH</b> <b>Jan. 15, 1884</b>		<b>9. AGE last birthday</b> <b>72</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Retired Tool Designer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Germany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>August Rau</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sophia</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. James Kotschenreuther, 8310 Harford</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <b>Hypertensive Cardiovascular</b>				<b>renal disease</b>		<b>3 yrs.</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<b>ANGINA PECTORIS.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Nov. 1955, to Feb. 5, 1956, that I last saw the deceased alive on Feb. 5, 1956, and that death occurred at 7:15 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>L. Nelson McKay</i> M.D.				<b>ADDRESS (Street, city, town, state)</b> <b>6014 Edmondson Ave</b>		<b>DATE SIGNED</b> <b>Feb. 5, 1956</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>2/8/1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Feb. 7, 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Victor E. Harvey</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01503  
1533 CERTIFICATE OF DEATH

Reg. Dist. No.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SPARROWS POINT (19)</u>		<u>19 YRS</u>		OR TOWN <u>SPARROWS POINT (19)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1027 H ST.</u>				STREET ADDRESS (If rural give location) <u>1027 H ST.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>MARY HANNAH REDMOND</u>				OF DEATH: <u>FEB. 26, 1956</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>FEB. 13, 1872</u>	9. AGE last birthday: IF UNDER 1 YEAR: <u>84.</u> yrs. Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>THOMAS MELVILLE</u>				14. MOTHER'S MAIDEN NAME: <u>MARY MCCARRAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE.</u>		17. INFORMANT & ADDRESS: <u>MRS. BERTHA SIMON - WEST CHESTER PENNA.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>Immediate</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerosis, heart failure</u>						<u>20 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1956</u> , to <u>February 26, 1956</u> , that I last saw the deceased alive on <u>February 24, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David Owens</u>		ADDRESS <u>M.D. Sparrows Point Md.</u>		DATE SIGNED <u>2/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAND</u>		LOCATION (City, town, or county) (State) <u>WEST CHESTER, PENNA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 29, 1956</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Larkins</u>		24. FUNERAL DIRECTOR: <u>Walter Burke Braddy, Randolph, Md</u>			

BUREAU V. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5706 Edmonston Ave.</u>		STREET ADDRESS (If rural, give location) <u>5706 Edmonston Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>HILDA</u> (Middle) <u>LOUISE</u> (Last) <u>REGAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-5-56</u> 19 <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1899</u>
9. AGE last birthday <u>56</u> yrs.		10. If under 1 year (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Kirchner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Winter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mr. F.L.Regan-5706 Edmonston Ave</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of Brain</u>	<u>7 Months</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 8/9, 1955, to 2/5, 1956, that I last saw the deceased alive on 1/26, 1956, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-8-56</u>	NAME OF CEMETERY OR CREMATORY <u>London Park</u>	LOCATION (City, town, or county) <u>Balto. City</u>	(State)
DATE REC'D BY LOCAL REG. <u>Feb-7, 1956</u>	REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>Fred A. Cole</u> <u>1515 W. Baltimore St.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1395 CERTIFICATE OF DEATH

Reg. Dist. No. 0150547

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Arbutus</u>		<u>Life</u>		OR TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5514 Carville Ave</u>				STREET ADDRESS (If rural give location) <u>5514 Carville Ave</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Tillie</u> <u>Rehling</u>				<u>Feb. 26</u> <u>19 56</u>			
<b>5. SEX</b>	<b>6. CO. OR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>F.</u>	<u>W.</u>	<u>Widow</u>	<u>Apr. 19, 1876</u>	<u>79</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>H.W.</u>		<u>O.H.</u>		<u>Balto. Md.</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Hucksoll</u>				<u>Anna</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<u>220-07-3598</u>		<u>Mrs Myrtle Karweick.</u>		<u>5514 Carville Ave</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>4440R</u> IMMEDIATE CAUSE (A) <u>Hypertensive U.S.C. V.N.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Terminal Uremia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>2/12</u>, 19<u>53</u>, to <u>2/26</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/26</u>, 19<u>56</u>, and that death occurred at <u>2:05</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John P. Vealy M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Harford, Md.</u>		<b>DATE SIGNED</b> <u>2/28/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Feb. 29/56</u>		<u>Western Cemetery</u>		<u>Balto. Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Mar. 1, 1956</u>		<u>Dr. Geo. S. M. Luper</u>		<u>Harold W. White</u>		<u>4101 Edmondson Ave</u>	

UNITED STATES

MAR 1 1956

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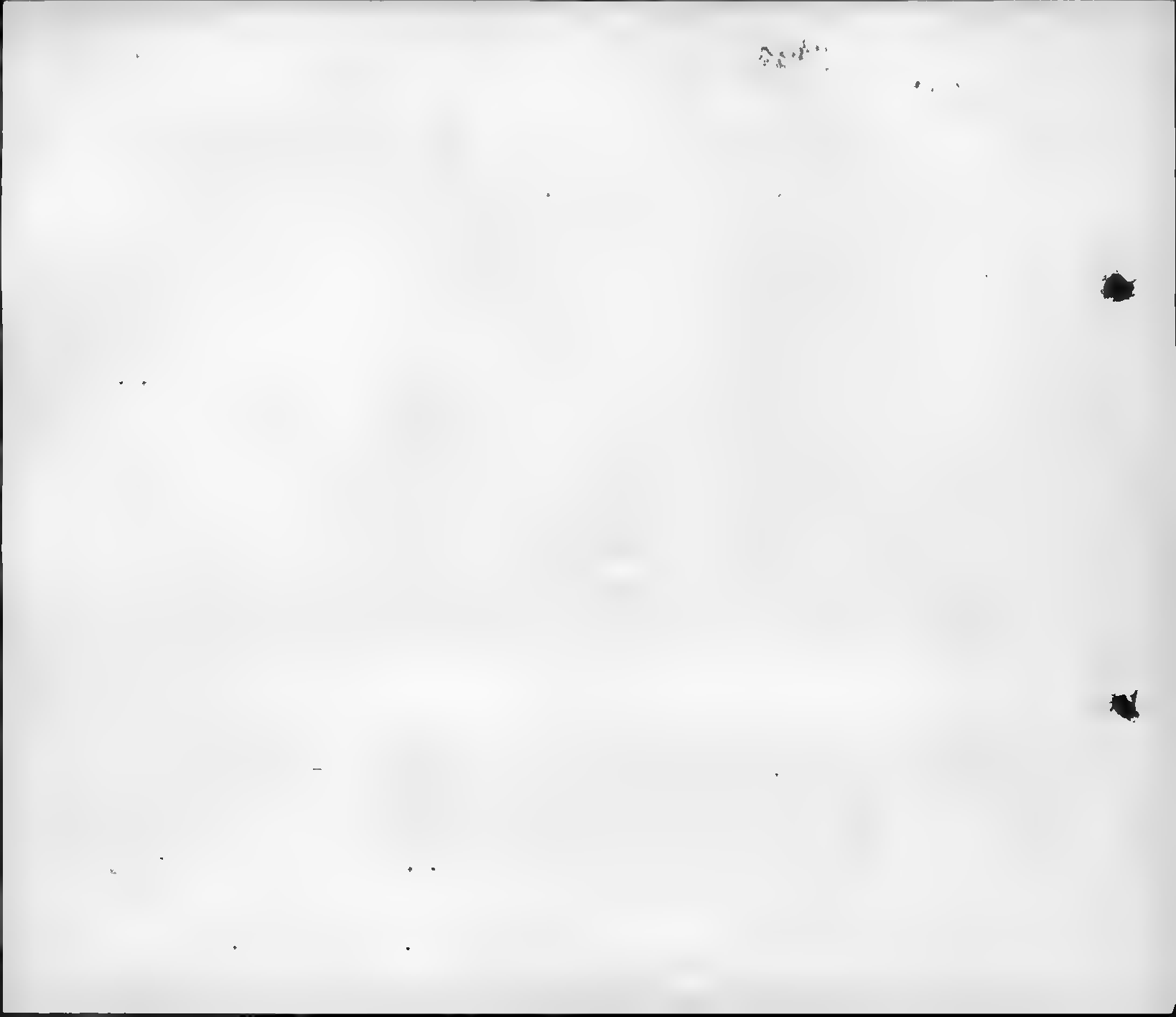
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Owings Mills, Maryland</u>		<u>8 1/2 yrs.</u>		OR TOWN <u>Baltimore, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Rosewood State Training School</u>		STREET ADDRESS (If rural give location) <u>4123 Grace Court</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Evelyn Beatrice Riggins</u>				OF DEATH <u>February 7th, 19 56</u>			
5. SEX. <u>female</u>		6. COLOR OR RACE. <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>single</u>		8. DATE OF BIRTH: <u>9/30/37</u>	
9. AGE last birthday <u>18</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
13. FATHER'S NAME: <u>Otis Brice Riggins</u>				14. MOTHER'S MAIDEN NAME: <u>Evelyn Virginia Clayton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>Rosewood Records</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute edema of brain with central respiratory</u>							
ANTECEDENT CAUSE (B) <u>Tumor 3rd Ventricle with hemorrhage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Tuberous Sclerosis with symptomatic epilepsy</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Tuberous sclerosis, Epilepsy, Hemiplegia, left</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>none</u>		<u>none</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>none</u>		<u>none</u>		<u>none</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>---</u>		<u>M.</u>		<u>----</u>			
22. I hereby certify that I attended the deceased from <u>2/6/</u> , 1956, to <u>2/7</u> , 1956, that I last saw the deceased alive on <u>2/7/</u> , 19 <u>56</u> , and that death occurred at <u>12:10 M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Harry B. Butler MD.</u>		<u>M. D. Owens Mills, Md.</u>		<u>8 Feb 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/11/56</u>		<u>Fork Methodist Cem.</u>		<u>Fork, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REG. STRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>Feb 9, 1956</u>		<u>H. B. Butler</u>		<u>Wm. J. Lickner &amp; Sons</u>		<u>Balto Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1536 CERTIFICATE OF DEATH

Item 2, Film 192 2-17-56 et Item 1, Film 192 2-20-56 et

Reg. Dist. No. 38

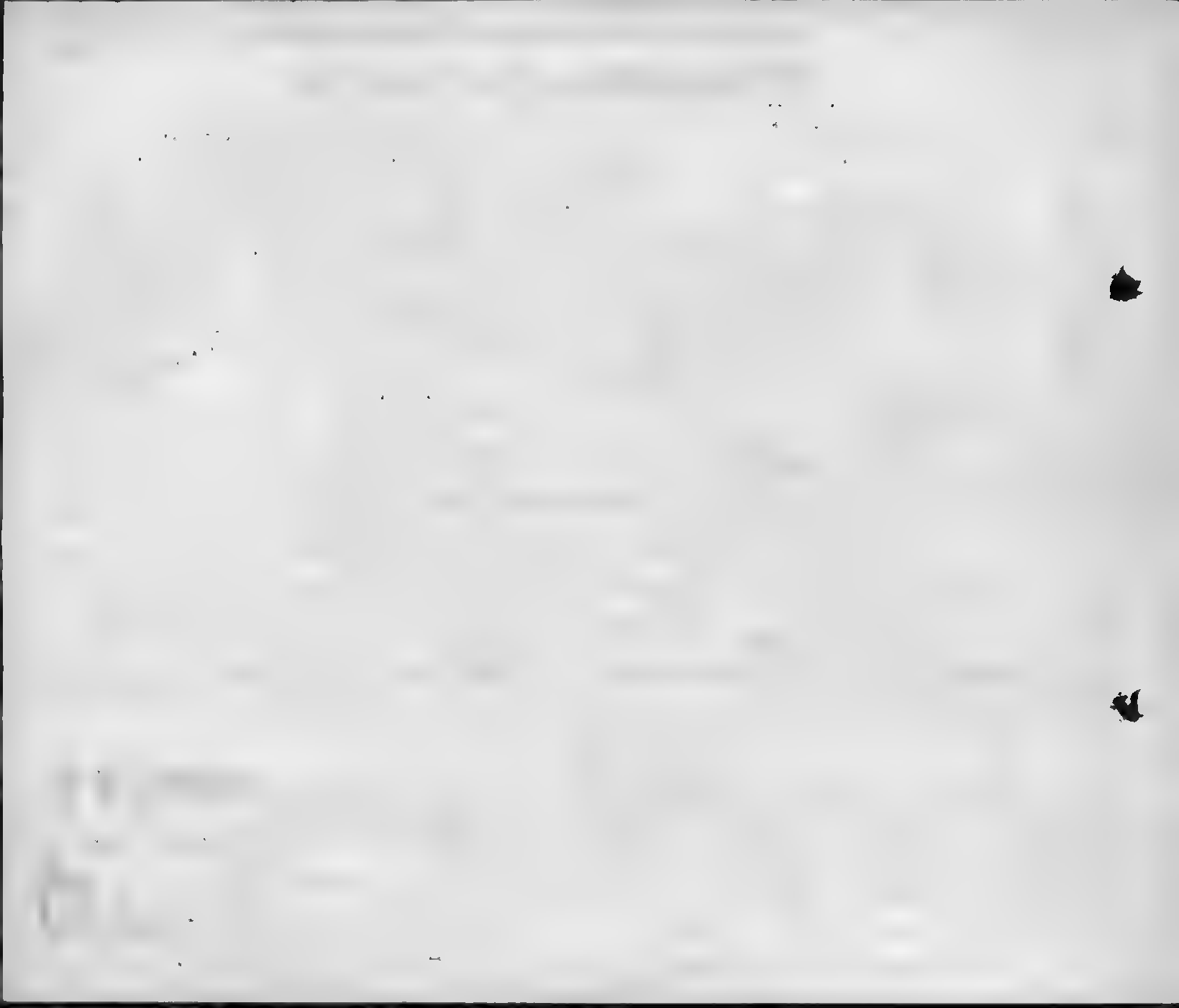
1. PLACE OF DEATH COUNTY <b>Balto.</b> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Stella Maris Hospice</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Md.</b> COUNTY <b>BALTO.</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>B/Towson Baltimore, 18</b> STREET ADDRESS <b>4409 Greenway Pot Spring Rd / Duane Valley</b>			
3. NAME OF DECEASED (First) <b>Cecilia</b> (Middle) <b>Riley</b> (Last) <b>Riley</b>				4. DATE OF DEATH (Month) <b>2</b> (Day) <b>8</b> (Year) <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>S</b>	8. DATE OF BIRTH <b>3/4/1874</b>		9. AGE last birthday <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Patrick Riley</b>				14. MOTHER'S MAIDEN NAME <b>Ann Byrnes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <b>Pulmonary Edema</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertension/Coronary</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Renal Vascular Disease</b>				19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <b>10 Hrs.</b> <b>10 yrs.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct 14, 1954</b> to <b>Feb 10, 1956</b> , that I last saw the deceased alive on <b>Feb 7, 1956</b> , and that death occurred at <b>11:14 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>Charles F. O'Donnell</b> M.D. ADDRESS (Street, city, town, state) <b>2501 York Rd #4 Md Baltimore</b> DATE SIGNED <b>2/10/56</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/11/1956</b>		NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
24. REC'D BY REGISTRAR DATE <b>Feb 10, 1956</b>		REGISTRAR'S SIGNATURE <b>Matel Gray</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Flynn Fleming</b>		ADDRESS <b>1426 Light St.</b>	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



## 1537 CERTIFICATE OF DEATH

Iter 2, FilmG193 2-27-56 et

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO.		MARYLAND		STATE MD		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CATONSVILLE		1 YR		TOWN CATONSVILLE		Ellicott city	
HOSPITAL OR INSTITUTION OR STREET ADDRESS CATONSVILLE CONV. HOME				STREET ADDRESS CATONSVILLE CONV. HOME			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
HARRY THOMAS RILEY				2/1/56		19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
M	W		2/27/1890	65	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ellicott Cr. Water Dept						P	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				HOSP. RECORDS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
Acute pulmonary edema						8 hrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
Left Ventric Failure; ASCVD						Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 2, 1955, to 2-1, 1956, that I last saw the deceased alive on 1-31, 1956, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Stephen L. Macpherson				M.D. 908 Fredericka Carmichael Rd		2-2-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/7/56		Good Shepherd		Howard Co	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 2-5-56		V.E. Harris		Macpherson		28	

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

STATE

MA

BUTLER

CHATELAIN

1891

CHATELAIN

CHATELAIN (Cousin)

CHATELAIN (Cousin)

HARRY CHAMBERLAIN

1891

2/1/91

2/1/91

CHATELAIN (Cousin)

CHATELAIN

CHATELAIN (Cousin) 2/1/91



01510

## 1538 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>New York</b>		COUNTY	
CITY (If outside corporate limits, write RURAL or give nearest town) <b>Ruxton</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Sorenson Nursing Home 7912 Ruxway</b>				STREET ADDRESS (If rural give location) <b>517 72nd Street</b>			
3. NAME OF DECEASED (Type or Print) <b>Mr. Leon S. Rivers</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>February 5th 19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>May 7, 1875</b>		9. AGE last birthday <b>80</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Augustus H. Rivers</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Stevenson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Mrs. C. L. Sommers, 715 Hillen Road</b>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <b>arteriosclerosis with infarct</b>						<b>year</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>degenerative arteriosclerosis</b>						<b>year</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 31, 19 56</b> , to <b>Feb 5, 19 56</b> , that I last saw the deceased alive on <b>Feb 4, 19 56</b> , and that death occurred at <b>12:20 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Ernest C Brown Jr.</b>				ADDRESS (Street, city, town, state) <b>M.D. 1101 N. Calvert St</b>		DATE SIGNED <b>Feb 6, 1956</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 7, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR <b>2/6/56</b>		REGISTRAR'S SIGNATURE <b>Ambedick / tef</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>		ADDRESS	

Mrs. Mabel Gray

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**1539** FOR MEDICAL EXAMINERS

01511

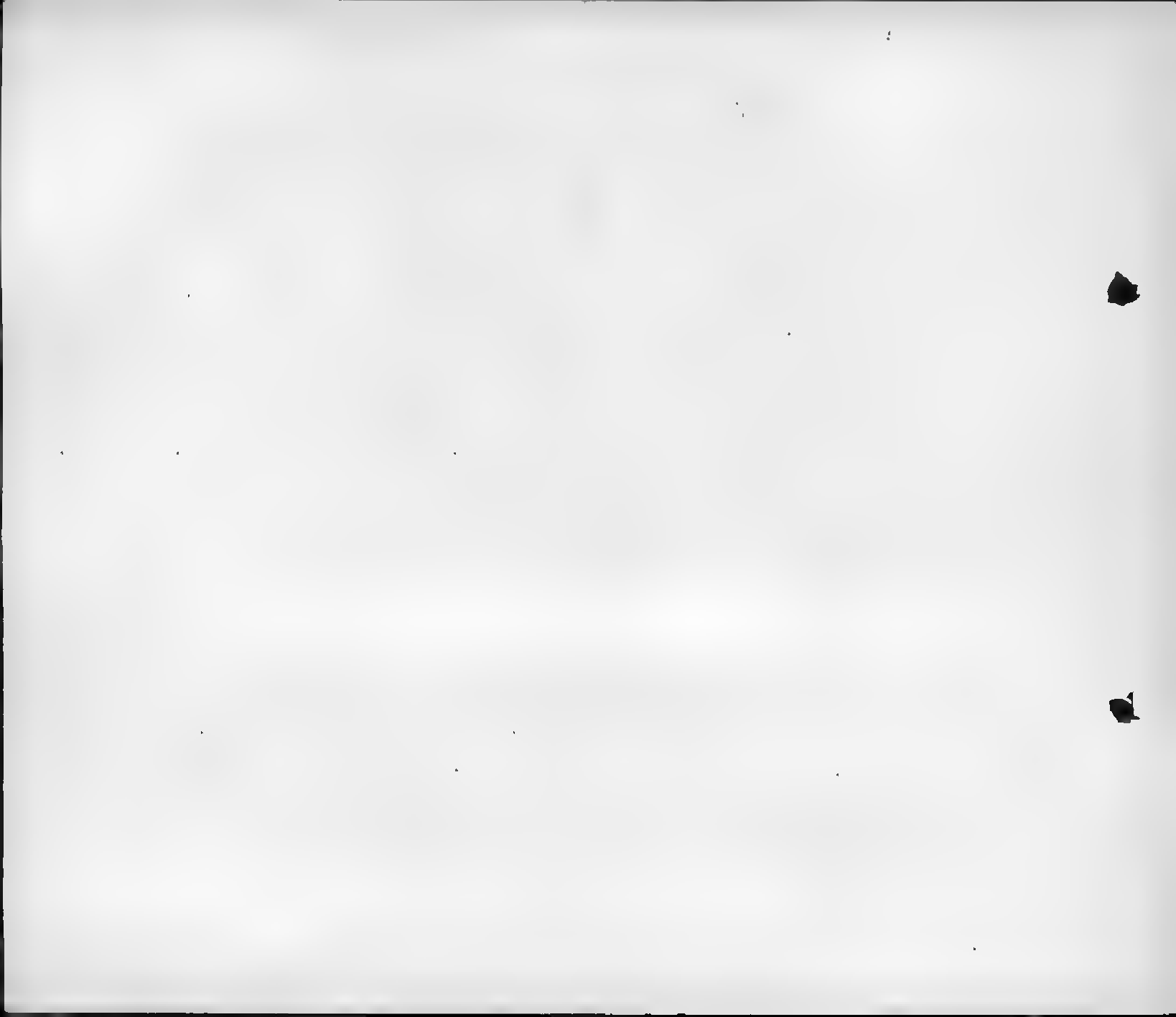
Reg. Dist. No. 30

<b>1. PLACE OF DEATH—</b> COUNTY <u>Catonsville BALTO</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN _____ LENGTH OF STAY (In this place) <u>2 wks</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring House State Hosp</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED—</b> STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore County</u> STREET ADDRESS (If rural, give location) <u>4301 Roland Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) L. <u>Corinne</u> (First) _____ (Middle) _____ (Last) <u>Roche</u>		<b>4. DATE OF DEATH</b> (Month) <u>Febr.</u> (Day) <u>22</u> (Year) <u>1956</u>	
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b> (Specify) <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>11/26/1874</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>
<b>13. FATHER'S NAME</b> <u>Charles Roche</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Medora Lintz</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY No.</b> <u>none</u>	<b>17. INFORMANT</b> <u>Mrs. Ethel Beary, 12 Dixie Dr. Towson, Md.</u>

<b>18. MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  Immediate cause (a) <u>Cardiac Failure</u>  Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Fracture of neck of right femur</u>				
<b>11. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.				
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING</b> <input checked="" type="checkbox"/>		<b>PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY</b> <u>hospit.</u>		
<b>TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <u>Febr. 6, 1956</u> m.		<b>INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>HOW DID INJURY OCCUR?</b> <u>Pt. had a fall</u>
<b>22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/>, accident <input checked="" type="checkbox"/>, suicide <input type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.</b>				
<b>SIGNATURE</b> <u>Dr. W. K. Hoffer</u>				<b>DATE SIGNED</b> <u>2/22/1956</u>
<b>23. BURIAL, CREMATION, REMOVAL</b> <u>2/24/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Green Mt</u>		
<b>DATE REC'D BY LOCAL REG.</b> <u>Feb 23, 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>A. W. Hedrich</u>		<b>24. FUNERAL DIRECTOR</b> <u>Wm Cook, Inc.</u>
<b>ADDRESS</b> <u>1217 St. Paul Street</u>				

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 1540 CERTIFICATE OF DEATH

Reg. Dist. No. 30

01512

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in Pines Nursing Home		STREET ADDRESS 511 N. Streep St.	
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print) JULIUS CHRISTIAN ROHRBACH. Sr.		4. DATE OF DEATH (Month) (Day) (Year) Feb. 4. 1956 19	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July. 19. 1880
9. AGE last birthday 75 yrs		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postoffice-Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired 15 yrs	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY SA	
13. FATHER'S NAME Wilhelm Rohrbach		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Julius Rohrbach Jr.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Coronary Thrombosis		1 hr.	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Hypertensive Cardio-Vascular Disease		15 yr.	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At work	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 2-2, 1952, to 2-4, 1956, that I last saw the deceased alive on 2-3, 1956, and that death occurred at 7:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Feb. 7. 1956		NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) Baltimore Md.	
DATE REC'D BY LOCAL REG. Feb 6, 1956		REGISTRAR'S SIGNATURE G. W. Hedrick		24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## 1541 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	<u>Essex</u>
TOWN <u>Essex</u>		STREET ADDRESS (If rural give location)	<u>817 Silver Avenue</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>817 Silver Avenue</u>			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>EDWARD A. ROLLISON</u>		OF DEATH <u>Feb. 27, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH <u>June 8, 1876</u>
9. AGE last birthday, IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min. <u>79</u> yrs			
10A. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Roberts Can Co.</u>	
11. FATHER'S NAME: <u>Edward A. Rollison</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME: <u>Isabella Simpson</u>		14. INFORMANT & ADDRESS: <u>Essex</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY NO. <u>214-03-1117</u>	
17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Generalized Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
ANTECEDENT CAUSE (S) (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST</u>			
(C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/15/56</u> 19, to <u>2/27/56</u> 19, that I last saw the deceased alive on <u>2/25/56</u> , 19, and that death occurred at <u>6A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Lyden</u>		DATE SIGNED <u>2/28/56</u>	
ADDRESS <u>M.D. 815 Eastern Ave.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>3/1/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		LOCATION ((City, town, or county) (State) <u>Paltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/29/56</u>		REGISTRAR'S SIGNATURE <u>Wm. Bork, Inc.</u>	
24. FUNERAL DIRECTOR <u>Wm. Bork, Inc.</u>		ADDRESS <u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1396

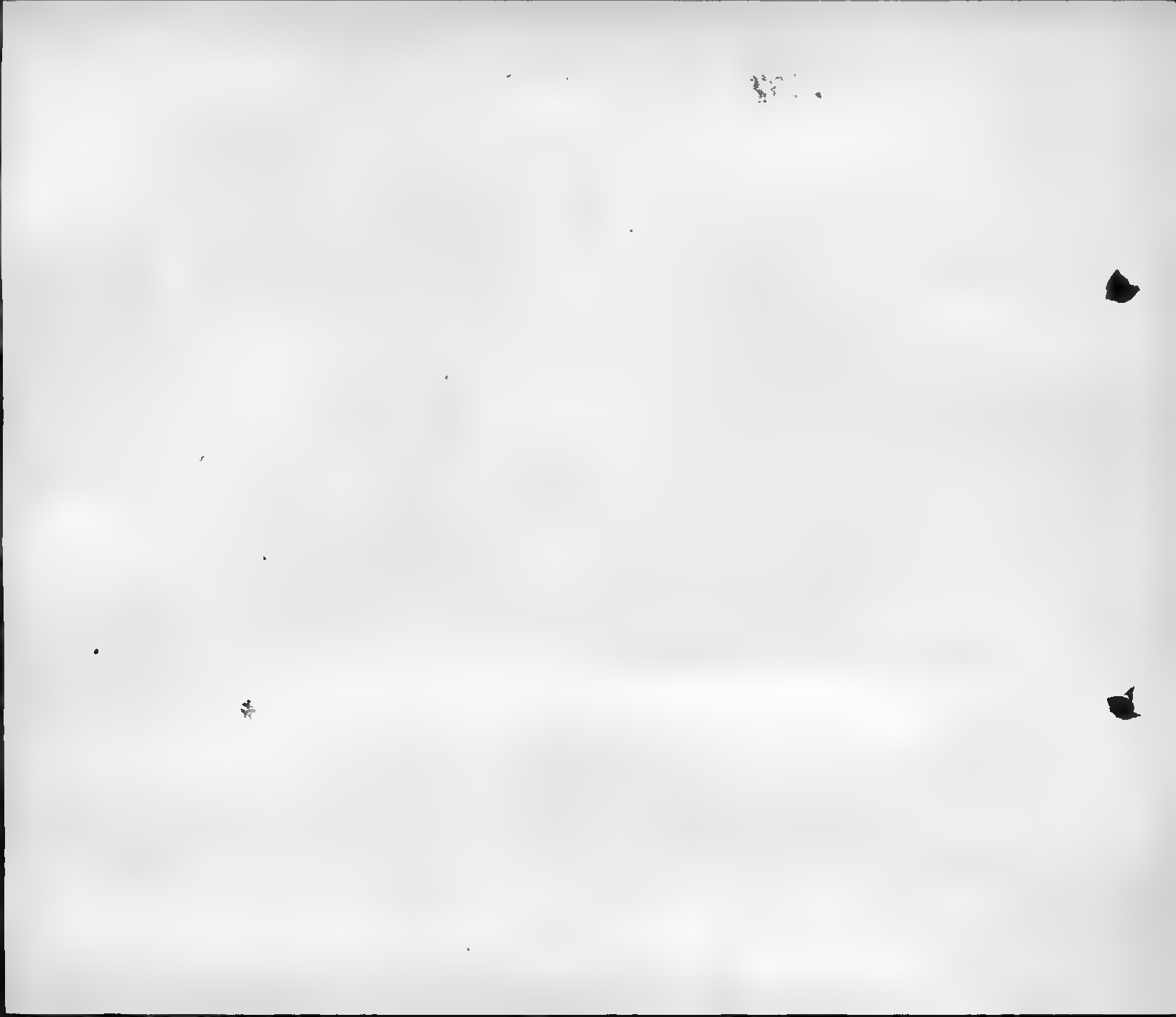
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5510 Willys Ave.</u>				STREET ADDRESS (If rural give location) <u>5510 Willys Ave.</u>			
3. NAME OF DECEASED: (Type or Print) (First) <u>ANNIE</u> (Middle) <u>E.</u> (Last) <u>ROLOFF</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>12</u> <u>19 56</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept. 9, 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Eli Caslow</u>				14. MOTHER'S MAIDEN NAME: <u>Annie C. Bortner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS: <u>Arbutus</u> <u>Mr. Henry A. Roloff Sr. - 5510 Willys Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic CVD</u>							
ANTECEDENT CAUSE (B) <u>Diabetes mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Myocardial infarction</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/2</u> , 1953 to <u>2/12</u> , 1956 that I last saw the deceased alive on <u>2/12</u> , 1956, and that death occurred at <u>402P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>2/12/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-5-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Sons - Balto 17</u>	

MARGIN RESERVED FOR INDEXING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

01515.

2411 N. Charles Street, Baltimore

1387

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk, Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3488 Dunhaven Road</u>		STREET ADDRESS (If rural, give location) <u>3488 Dunhaven Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bronislawa</u>	(Middle) <u>-</u>	(Last) <u>Ruzakowski</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>Ignatz (L.N. Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Wolkiewicz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>--</u>	
17. INFORMANT AND ADDRESS <u>Frank Ruzakowski</u>		<u>3488 Dunhaven Rd.</u> <u>Dundalk, 22- Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Mercuric thrombosis</u>		<u>6 days</u>	
Antecedent cause(s) (b) <u>Hypertension - genl.</u>		<u>20 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dr. apoplexy</u>		<u>20 yrs</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1955 to 2-3, 1956, that I last saw the deceased alive on 2-2, 1956, and that death occurred at 6 PM m., from the causes and on the date stated above.

SIGNATURE Dr. William H. Pratt ADDRESS Belt 22 DATE SIGNED 2-4-56  
(Degree or title)

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2/7/56 NAME OF CEMETERY OR CREMATORY Holy Rosary LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. FEB 5 - 1956 REGISTRAR'S SIGNATURE William H. Pratt 24. FUNERAL DIRECTOR ADDRESS 10010, Dunham Dr. Balt - 4, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

S. A. 11111



1542 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTC.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FORT HOWARD</u>	LENGTH OF STAY (in this place) <u>9 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS <u>3016 SPARROWS POINT ROAD</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>RICHARD</u> <u>FILLMORE</u> <u>SANDERS</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 12</u> <u>19 56</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>3-24-93</u>
9. AGE last birthday, IF UNDER 1 YEAR, IF UNDER 24 HRS., <u>62</u> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ERECTOR</u>	
11. BIRTHPLACE (State or foreign country): <u>Richmond, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Mell Sanders</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Marks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>216-10-4144</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>BRONCHOGENIC CARCINOMA RIGHT LUNG</u>		UNKNOWN	
(B) ANTECEDENT CAUSE (S) <u>TOXIC WITH METASTASIS TO BRAIN</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 3, 1956, to Feb. 12, 1956, that I last saw the deceased on Feb. 12, 1956, and that death occurred at 3:15 AM, from the causes and on the date stated above.			
SIGNATURE <u>D. J. Vah, M.D.</u>		ADDRESS <u>M.D. Vah, Fort Howard, Md.</u>	
DATE SIGNED <u>2-12-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-15-56</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 16 1956</u>		REGISTRAR'S SIGNATURE <u>Walter Brooks Bradley</u>	
ADDRESS <u>700 Willow Spring Rd., Baltimore 22, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01517

## 1388 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO		MARYLAND		STATE MD		COUNTY BALTO	
CITY (If outside corporate limits, write RURAL OR and give nearest town) DUNDALK		LENGTH OF STAY (in this place) 22 YRS		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3009 DUNBRIN RD.				STREET ADDRESS (If rural give location) 3009 DUNBRIN RD.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MELVIN GEORGE SANDLER				4. DATE OF DEATH (Month) (Day) (Year) 2-16-56			
5. SEX M.	6. RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPT. 27, 1902	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHICER			10b. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANDREW E. SANDLER				14. MOTHER'S MAIDEN NAME CATHERINE ROHMANN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS MILDRED H. SANDLER - SAME		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Thrombosis						1 week	
ANTECEDENT CAUSE(S) DUE TO mild Hypertension						3 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Obesity							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) M.			21e. INJURY OCCURRED While <input type="checkbox"/> at work Not-white <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 2-10-56, 1956, to 2-16-56, 1956, that I last saw the deceased alive on 2-12-56, 1956, and that death occurred at 8 A.M. from the causes and on the date stated above.							
SIGNATURE Eugene F. Nery, M.D.				ADDRESS (Street, city, town, state) 7001 Morningstar Rd Dundalk, Md.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 2/18/56		NAME OF CEMETERY OR CREMATORY CARM LAWN		LOCATION (City, town, or county) BALTO. CO. MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE William M. Kelly		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Feb 18-1956							





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01518

## 1543 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>606 Anneslie Road</b>				STREET ADDRESS (If rural give location) <b>606 Anneslie Road</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) Mrs. <b>Josephine A. Sauerwein</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>February 13 1956</b>			
<b>5. SEX</b> female	<b>6. COLOR OR RACE</b> white	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> married	<b>8. DATE OF BIRTH</b> Aug. 21, 1896		<b>9. AGE last birthday</b> 59 yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) at home		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) Baltimore, Maryland		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> Mr. James Bacon				<b>14. MOTHER'S MAIDEN NAME</b> Lydia Gallagher			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> Mr. George P. Sauerwein, 606 Anneslie Rd.			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>30 min</b>			
<b>IMMEDIATE CAUSE (A)</b> Myocardial Infarction							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> Hypertension & Atherosclerosis							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> Hypertension & Diabetes Mellitus				<b>2 yrs.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from August 1954 to February 1956, that I last saw the deceased alive on Feb 13, 1956, and that death occurred at 4:40 AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Charles G. ...</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) 6501 York Rd Baltimore, Maryland		<b>DATE SIGNED</b> 2/13/56	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> Burial		<b>DATE THEREOF</b> 2/16/1956		<b>NAME OF CEMETERY OR CREMATORY</b> New Cathedral Cemetery		<b>LOCATION</b> (City, town, or county) (State) Baltimore, Maryland	
<b>24. REC'D BY REGISTRAR</b> DATE <b>2-15-1956</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mark Gray</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> Leonard J. Ruck, 5305 Harford Road #14			

1972

BUREAU V. S.

FEB 16

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

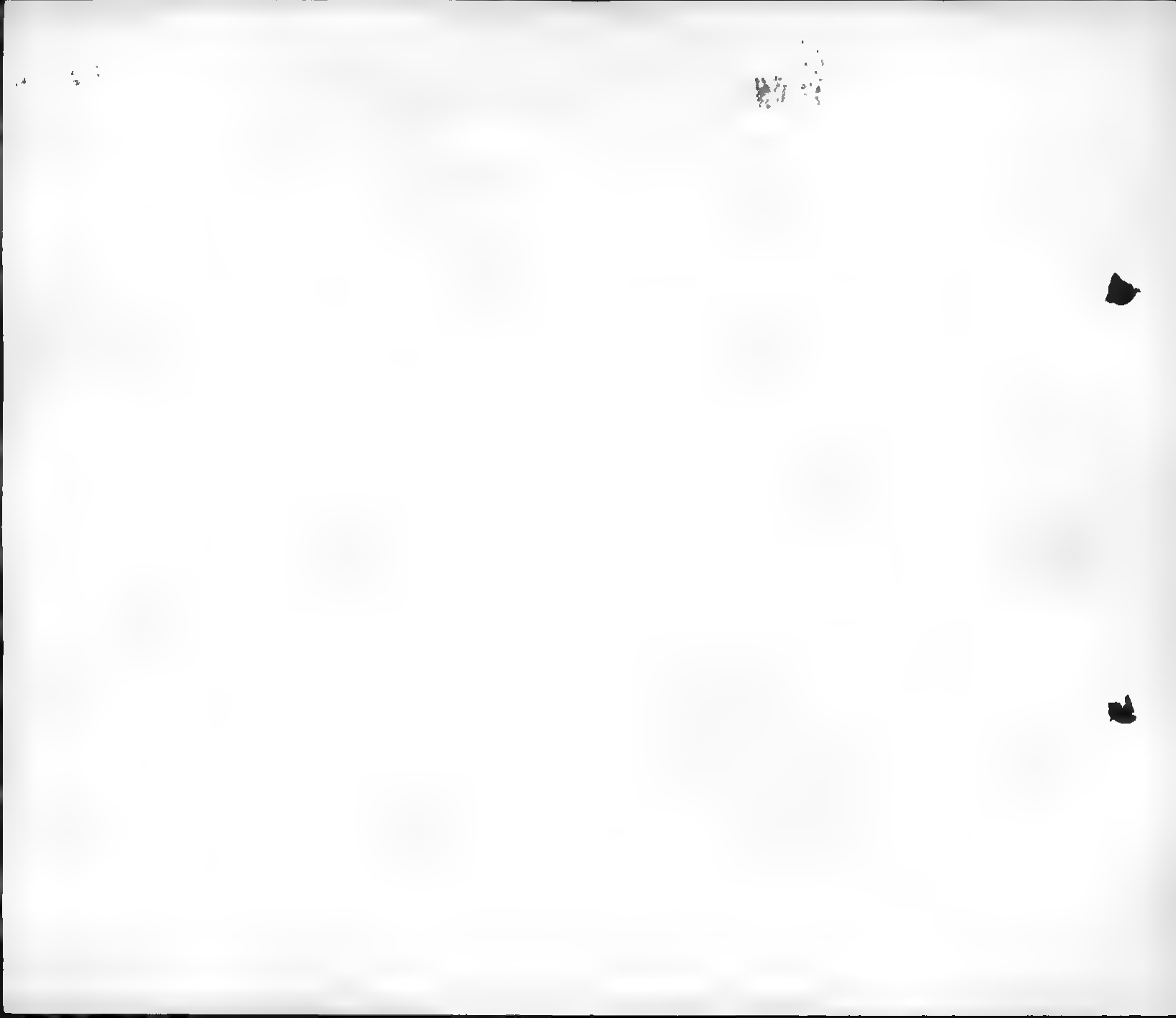
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801519

1397

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>51 TOWN ARBUTHUS</u>		LENGTH OF STAY (in this place) <u>12 yrs.</u>		CITY: If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>ARBUTHUS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1326 BIRCH AVE</u>				STREET ADDRESS (If rural give location) <u>1326 BIRCH AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FLORENCE V. SCHAEFER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>FEB. 22 1956</u>			
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>NOV. 5, 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK OWN HOME</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>MARYLAND.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William H. Orem.</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE MILLER.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NONE</u>				17. INFORMANT & ADDRESS: <u>MRS. LOUIS HOUSTON 1326 BIRCH AVE.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>1 hr</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis Generalized</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardiovascular Disease 10 yrs.</u>							
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>Feb 22, 1956</u> , that I last saw the deceased alive on <u>Dec 7, 1955</u> , and that death occurred at <u>11 A M</u> , from the causes and on the date stated above. SIGNATURE <u>Dr. Bradley Saughasthy MD</u> ADDRESS <u>1264 Francis Ave Baltimore 27 Md</u> DATE SIGNED <u>2-21-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>LORDAINE PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>B. B. H. A. B.</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>Joseph J. Ambrose, 71328 Sulphur Sp. Rd.</u>		ADDRESS	



1544  
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5602 Windsor Mill Rd.</u>				STREET ADDRESS (If rural give location) <u>5602 Windsor Mill Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>William Frederick Schmidt</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>5</u> <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Apr. 20, 1880</u>	9. AGE last birthday: <u>75</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cabinet maker</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Wm. Harbaugh</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME: <u>John Schmidt</u>				14. MOTHER'S MAIDEN NAME: <u>Victoria Geise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>215-10-7374</u>		17. INFORMANT & ADDRESS: <u>Marie Schmidt - 5602 Windsor Mill Rd.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>10 weeks</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis of Aorta</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <u>Arteriosclerosis C-U-D-E</u>							
DUE TO <u>Coronary Heart Failure</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1944, to <u>2-5</u> , 1956, that I last saw the deceased alive on <u>2-2</u> , 1956, and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sean A. Sullivan</u>		ADDRESS <u>5907 Aragon Park Dr</u>		DATE SIGNED <u>2-7-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 8, 1956</u>		REGISTRAR'S SIGNATURE <u>W. H. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hgts. Ave.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1545

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

Catonville

LENGTH OF STAY (in this place)

30 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

612 Plymouth Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

Md Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Catonville

STREET ADDRESS

612 Plymouth Road

## 3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

KARL

SCHMIED

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

Feb 9

19 56

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

Widowed

Oct. 16, 1861

94 yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life. (yes or no):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

Safety

German Orphan Home

Switzerland

U.S.A.

## 13. FATHER'S NAME:

Unknown

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

None

none

Otto K. Schmied 1317 Hindermere Pkwy 18

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) Arteriosclerotic Heart Disease

unknown

DUE TO

## Antecedent cause(s)

(b) Generalized Arteriosclerosis

unknown

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1949...., to..... Feb....., 1956...., that I last saw the deceased alive on..... Feb....., 1956...., and that death occurred at..... 9:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS 1 Mallow Hill Ave., Baltimore 29, Md

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/10/56

V.E. Harry

John H. Seigel 5311 Edmondson Ave

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12

13

14

15

16



## 1546 CERTIFICATE OF DEATH

Items 8,9: film G193 3-5-56L

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE MD.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6314 Frederick Ave.				STREET ADDRESS (If rural give location) 6314 Frederick Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Rust (Middle) -- (Last) Scott				(Month) Feb. 14 (Day) 19 (Year) 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
			April 24, 1893	62 97 yrs	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ticket Mgr.		Sales - Vermont		Vermont			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lucius B. Scott				Jeanie Furrill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Mrs. Ella Scott 6314 Fred. Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						2 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO						6 yr.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-20, 1944, to 2-14, 1956, that I last saw the deceased alive on 2-13, 1956, and that death occurred at 5 P. M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Walter K. Gallagher				M.D. 6209 Frederick Rd. Baltimore Md. 2/14/56			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
removal		2-14-56		Leury Cemetery		Richmond Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Feb. 16, 1956		T. E. Harris		F. H. Funeral Home, Catonsville, Md.			

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

BUREAU V. S.

FEB 16 1

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01523

Items 8 &amp; 9: Film G194

3/14/56 dmr.

1547

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port Howard</u>	LENGTH OF STAY (in this place) <u>18 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>2640 E. Oliver Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM A SCOTT JR.</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 21 1956</u>	
5. SEX. <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH. <u>12/16/97 97</u>
9. AGE last birthday: <u>58</u> yrs.		10. MONTHS: <u>14</u>	11. DAYS: <u>14</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Plumber</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William A. Scott, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Susan R. Bears</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA LEFT UPPER LOBE</u>		UNKNOWN	
ANTECEDENT CAUSE (B) <u>999999 WITH METASTASIS TO KIDNEYS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>DUE TO</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>LOBULAR PNEUMONIA</u>		UNKNOWN	
19A. DATE OF OPERATION: <u>VA</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 5, 1956, to Feb. 21, 1956, that I last saw the deceased <u>alive on 19XXXX</u> and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>D. MARK, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>2-22-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
Burial		2-22-56	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Baltimore National Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
11-23-1952		Leo G. Cook	
REGISTRAR'S SIGNATURE <u>W. W. Hedrick</u>		ADDRESS <u>1703 N. Paterson Park Ave. Balto. Md.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

1548

## CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>10 yr 2 mos 12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS <u>Helping Up Mission Lombard &amp; Green Sts.</u>	
3. NAME OF DECEASED (Type or Print) <u>Fred</u>		(First) (Middle) (Last) <u>Seiling</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 3, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-11-1880</u>	9. AGE last birthday <u>75</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Seiling</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Whipple</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Lobar pneumonia

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Carcinoma of stomach

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Name or title)

ADDRESS

DATE SIGNED

Geo. McKieffer1010 Leeds AveBaltimoreMD2/3/56

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

Feb 6, 1956J. E. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

Wm Cook Inc - 1217 St Paul st

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



ADDRESS

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01526

## 1550 CERTIFICATE OF DEATH

Reg. Dist. No. 37

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lutherville</u>				TOWN <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bellona Avenue</u>				STREET ADDRESS (If rural give location) <u>Bellona Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>JOHN BARCLAY SHOCK</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>FEB. 24, 1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>May 26, 1894</u>		<b>9. AGE last birthday</b> <u>61</u> yrs	<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <u>IF UNDER 24 HRS.</u> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Crown Cork &amp; Seal</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George Shock</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca Parks</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Family Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Coronary Heart Disease,</u>				INTERVAL BETWEEN ONSET AND DEATH <u>74.00.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>2-28-56</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>M.</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>6/28, 1955</u> , to <u>2/24, 1956</u> , that I last saw the deceased alive on <u>11/28, 1955</u> , and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Bennett A. Hester M.D. Consultant M.E. Lutherville</u>				<b>ADDRESS</b> (Street, city, town, state) <u>422/56.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. 28, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Prospect Hill Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Towson, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>6</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Anne D. McLaughlin</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burns' Sons,</u>		<b>ADDRESS</b> <u>Towson, Maryland</u>	

RECEIVED  
FEB 29 1956  
U. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1551

## CERTIFICATE OF DEATH

01527

Reg. Dist. No. 30

FilnG193 2-28-56 et

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>CALVERVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PARADISE HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>ESSEX</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 25</u> STREET ADDRESS <u>414 Maude Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGARET SKINNER</u>				4. DATE OF DEATH (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>3/25/17</u>	9. AGE last birthday <u>38</u> yrs.	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES SKINNER</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE JOSEPHINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1</u>		17. INFORMANT & ADDRESS <u>1226 Hanover St - Baltimore</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10/4/52	
IMMEDIATE CAUSE (A) <u>Hypertensive cardio vascular disease,</u>						3/53	
ANTECEDENT CAUSE(S) DUE TO <u>endarteritis obliterans right leg.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>Diabetes Mellitus</u>						?	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/4/52</u> , 19 <u>52</u> , to <u>Feb 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 14</u> , 19 <u>56</u> , and that death occurred at <u>1226 Hanover Street</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harry Replee</u> M.D.				DATE SIGNED <u>2/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>2/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>PARK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE</u>	
24. REC'D BY REGISTRAR <u>EB 20 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Barry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>See Clergy - Funeral Home</u>		ADDRESS	



1552

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

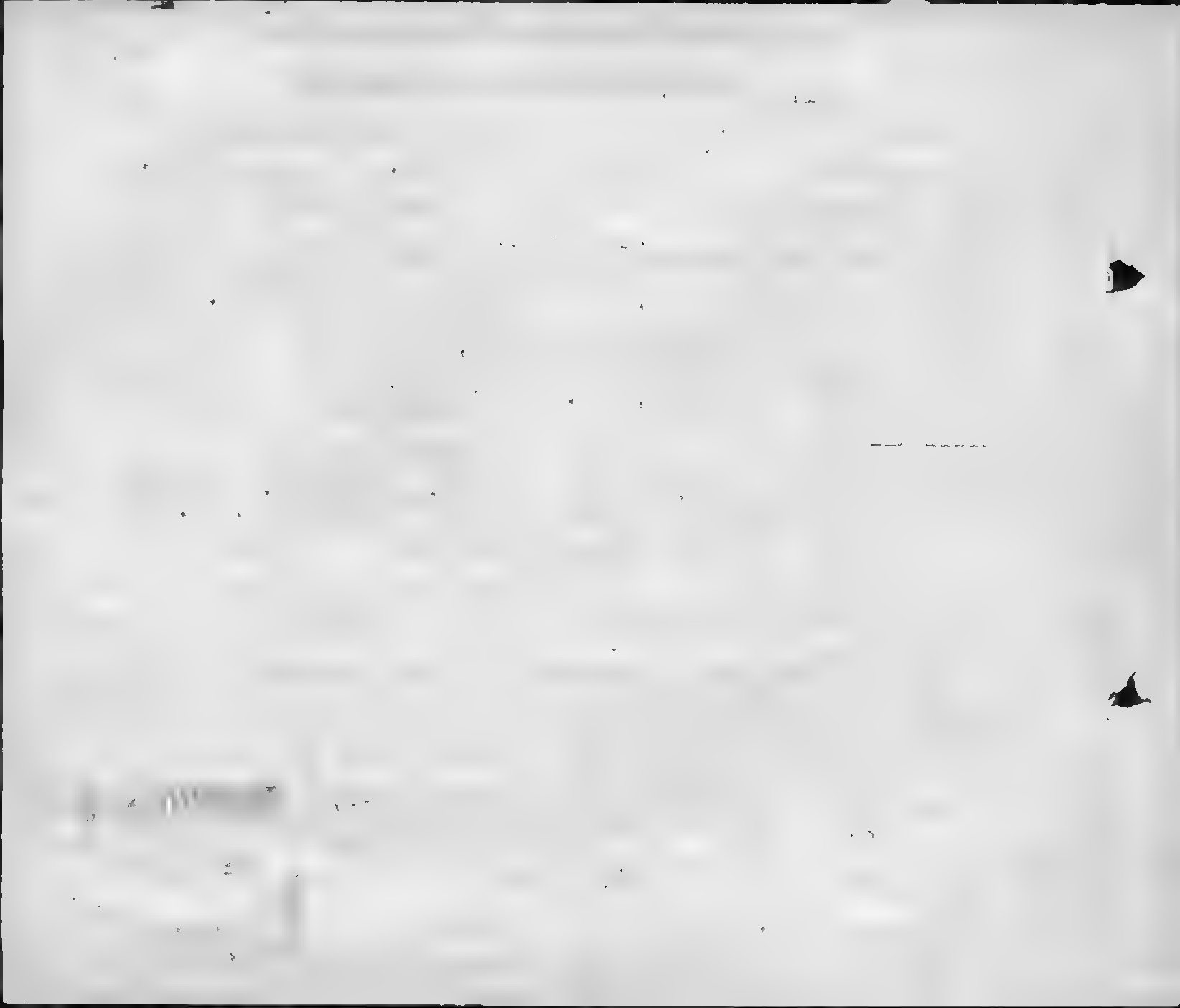
1. PLACE OF DEATH				2. MARRIAGE HISTORY			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2403 Old Frederick Rd</u>				STREET ADDRESS (If rural give location) <u>2403 Old Frederick Rd</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Edward W. Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17/56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 10, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brinks, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Smith</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes no war</u>		16. SOCIAL SECURITY NO. <u>679 20 2192</u>		17. INFORMANT & ADDRESS <u>Mrs. Florence F. Smith, 2403 Old Frederick Rd. Cat. 28</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Carcinoma (metastatic) liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma; prostate</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-5</u> , 19 <u>55</u> , to <u>2-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stephen L. Magness M.D.</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>908 Frederick Rd. Catonsville, Md. 2-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Balto. 29 Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Feb. 21 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>Edmondson Ave</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01529

## 1553 CERTIFICATE OF DEATH

Reg. Dist. No. 37

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>	LENGTH OF STAY (in this place) <u>3 year</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3Vc</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home of Md</u>		STREET ADDRESS (If rural give location) <u>3402 St. Andrew Ave.</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Sallie</u> (First) <u>Sommerwerck</u> (Middle) (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb.</u> <u>23</u> 19 <u>56</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>July 26, 1878</u>
<b>9. AGE last birthday</b> <u>77</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Alfred Clatchey</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Rhoda B. Staunberry</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or date of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>Alfred Dimis - Masonic Home</u>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardio-Cerebral Disease</u>		<u>3 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 22, 1953</u>, to <u>Feb 23</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Feb 22</u>, 19<u>56</u>, and that death occurred at <u>3:22</u> M, from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>Walter S. Kees</u>		<b>ADDRESS (Street, city, town, state)</b> <u>Cockeysville, Md</u>	
<b>DATE SIGNED</b> <u>2/23/56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Feb. 25, 1956</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore Md</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>FEB 27 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Anne MacRae</u>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm W. W. W.</u>		<b>ADDRESS</b> <u>1217 St. ...</u>	





**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

156-AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

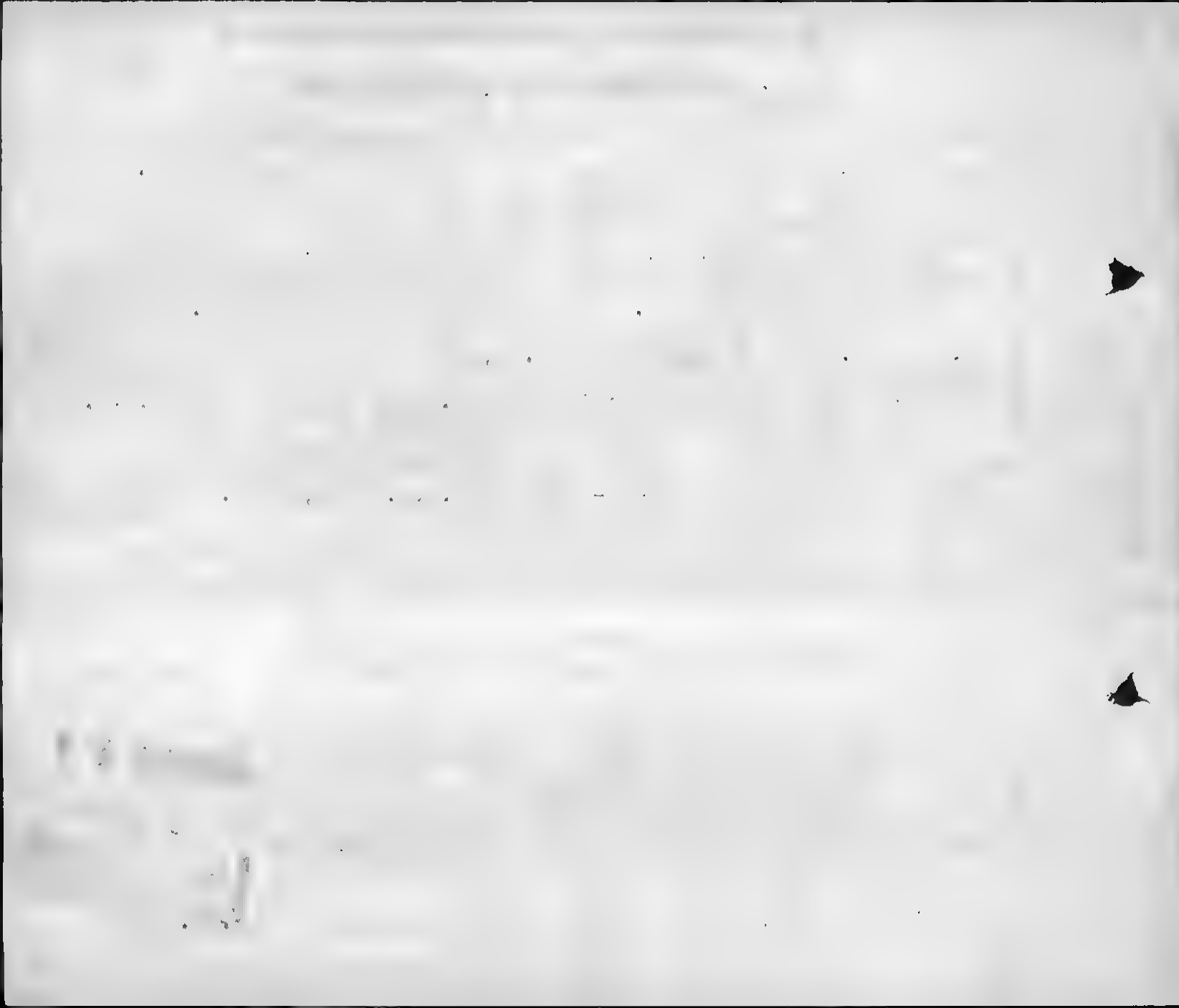
1554

# CERTIFICATE OF DEATH

01500

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>		LENGTH OF STAY (In this place) <u>30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2001 Windsor Place</u>				STREET ADDRESS (If rural give location) <u>2001 Windsor Place</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Annie K. Souder</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Feb. 24 19 56</u>			
<b>5. SEX</b> <u>F.</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 14, 1874</u>		<b>9. AGE last birthday</b> <u>81</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Kelly Clinic</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>216-10-6216</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr. I. N. Smith, 602 N. Franklintown Rd</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC Cardiovascular</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3+ yrs</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>JAN 19 53</u>, to <u>2/24, 1956</u>, that I last saw the deceased alive on <u>2/23</u>, 1956, and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>John E. Roach</u>		<b>DATE THEREOF</b> <u>Feb. 27/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Louison Park</u>		<b>LOCATION (City, town, or county)</b> <u>Balto. Md.</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b> DATE		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harry H. Wolfe</u>		<b>ADDRESS</b> <u>4101 Edmondson Ave</u>	



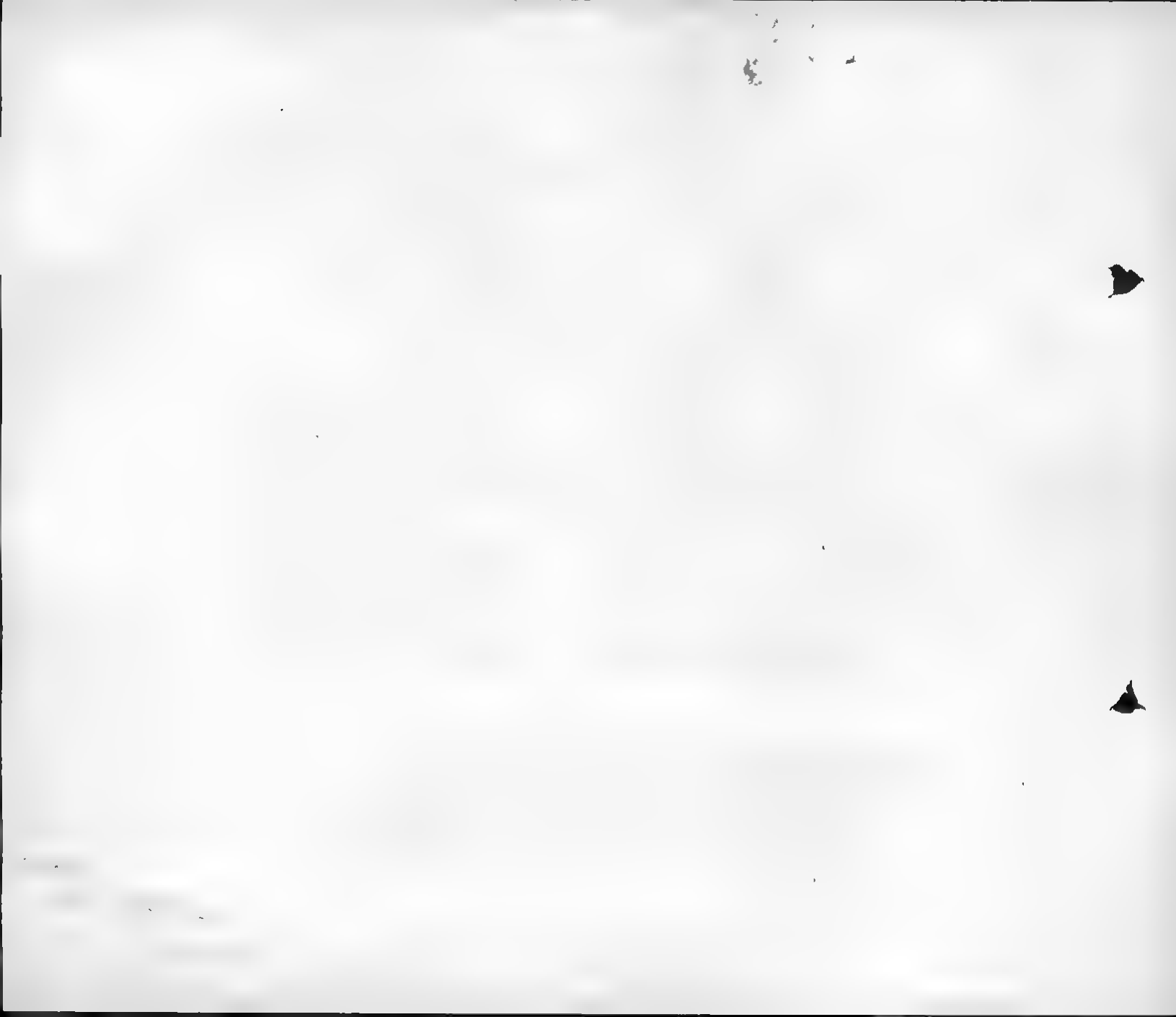
## 1398 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ARBUTUS</u>	<u>34 yrs.</u>	OR TOWN <u>ARBUTUS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>1244 STEUENS AVE.</u>		<u>1244 STEUENS AVE</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>FLORENCE</u>	(Middle) <u>SPIEKER</u>	(Month) <u>2</u>	(Day) <u>6</u>
(Type or Print)		(Year) <u>1956</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>9-2-1875</u>
		9. AGE last birthday: <u>77</u> yrs	10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSE WORK</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country): <u>BALTO. MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>WILLIAM HOFFMAN</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZABETH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
		17. INFORMANT & ADDRESS: <u>HUSBAND EDWARD H. SPIEKER (SAME)</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>chronic hypertension - aortic atherosclerosis</u>			<u>740 -</u>
ANTECEDENT CAUSE (B) <u>Myocarditis - a decompensation</u>			<u>3,000 -</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1930</u> , to <u>Feb. 6th 1956</u> , that I last saw the deceased alive on <u>Feb 5</u> , 1956, and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frederic D. Becker</u>		DATE SIGNED <u>M.D. 1014 Francis St. Balto. 2-7-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>LODON, PK BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/8/56</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. Walter Conklin 5444 BELAIR RD</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1555 CERTIFICATE OF DEATH

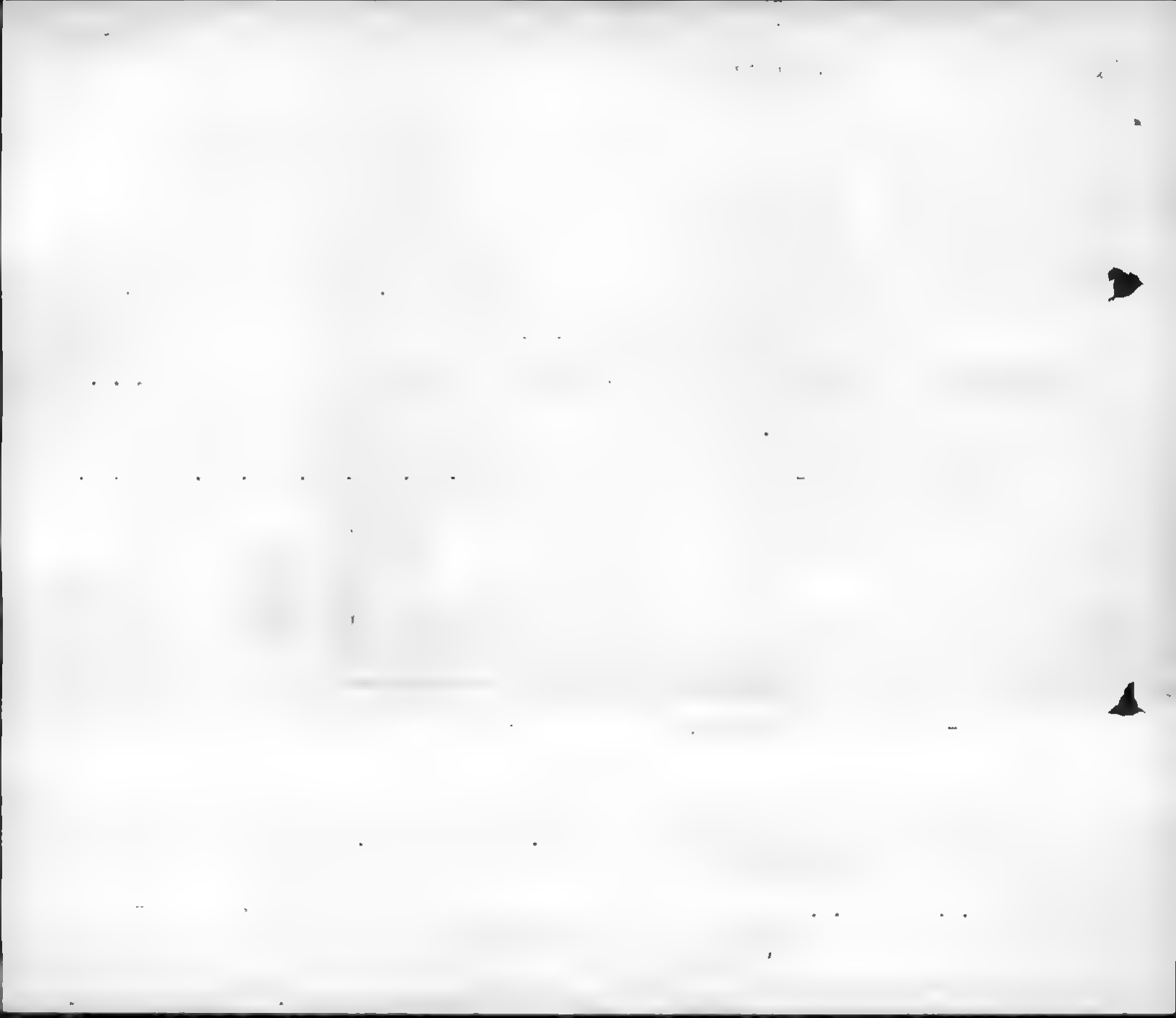
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FORT HOWARD</u> <u>6 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>3315 EDMONDSON AVENUE</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>DAVID</u> (NMI) <u>SPRINGER, Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>February 12, 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH. <u>8-26-26</u>
9. AGE last birthday <u>29</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY. <u>Plywood Corporation</u>	
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Springer, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Freida Gephardt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>P1-28</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CEREBRAL EMBOLISM</u>		<u>6 DAYS</u>	
ANTECEDENT CAUSE (B) DUE TO <u>RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS</u>		<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CEREBRAL VESSEL ANEURYSM</u>		<u>CONGENITAL</u>	
19A. DATE OF OPERATION: <u>12-10-55; 12-11-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>INTERNAL CAROTID ARTERY ARTERIOGRAM &amp; TRACHEOTOMY; EXPLORATION OF RIGHT</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Feb. 6, 1956</u> to <u>Feb. 12, 1956</u> , that I saw the deceased <u>alive</u> , and that death occurred at <u>3:55 am</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. P. COPE, M.D.</u>		ADDRESS <u>M D VAH, Fort Howard, Md.</u> DATE SIGNED <u>2-12-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Feb. 15/56</u> NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-15-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>WITZKE FUNERAL DIRECTORS 1101 Edmondson Ave., Baltimore 29, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 -- 10-63

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1556 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>OR</u> TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>		STREET ADDRESS (If rural give location) <u>2733 St. Paul St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOHN R. M. STAUM</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 16, 1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Mar. 1, 1873</u>
9. AGE last birthday: <u>82</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Lawyer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Wesley Staum</u>		14. MOTHER'S MAIDEN NAME: <u>Juliet Armager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr. John W. Staum - 3818 Greenmount Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>+91X</u>		<u>5 da</u>	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Broncho-Pneumonia</u>			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Ch. Hypertensive Cardio-Vascular Disease</u>		<u>15 yr. (P.)</u>	
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-26, 1955</u> , to <u>2-16, 1956</u> , that I last saw the deceased alive on <u>2-16, 1956</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wilmon K. Gallagher</u>		ADDRESS <u>M. D. Catonsville - 28, 7nd.</u>	
DATE SIGNED <u>2-17-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/18/56</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>February 18-1956</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>Wm. J. Tichner &amp; Sons - Balto.</u>	ADDRESS <u>17 Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## 1557 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MD.</b>	COUNTY <b>BALTO.</b>
CITY (If outside corporate limits, write RURAL OR TOWN) <b>CATONSVILLE</b>	LENGTH OF STAY (in this place) <b>2 YEARS, 11 MONTHS</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Daniels</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>SPRING GROVE STATE HOSP.</b>		STREET ADDRESS (If rural give location) <b>DANIELS, MD</b>	
3. NAME OF DECEASED: (First) <b>ALICE</b> (Middle) <b>C</b> (Last) <b>STEWART</b>		4. DATE (Month) (Day) (Year) OF DEATH. <b>8 22 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>MARRIED</b>	8. DATE OF BIRTH. <b>? UNKNOWN</b>
9. AGE last birthday <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>W. VIRGINIA</b>
13. FATHER'S NAME: <b>J. H. WALKER</b>		14. MOTHER'S MAIDEN NAME: <b>ANNIE ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT & ADDRESS: <b>MRS. RICHARD LANDACRE</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>CARDIAC FAILURE</b>		<b>2/19/56</b>	
ANTECEDENT CAUSE (B) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>		<b>2/22/56</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>DIABETES - CONVULSIVE DISORDER</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/3</b> , 19 <b>54</b> , to <b>2/22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/22</b> , 19 <b>56</b> , and that death occurred at <b>12<sup>20</sup></b> A.M., from the causes and on the date stated above.			
SIGNATURE <b>Stella Hachler</b>		DATE SIGNED <b>2/28/56</b>	
M. D. <b>Spring Grove St. Hospital</b>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <b>2/24/56</b>	NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>[Signature]</b>	24. FUNERAL DIRECTOR ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Item 8 Film 193 2-24-56 et

1558

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Burke Avenue</u>				STREET ADDRESS (If rural give location) <u>8 Burke Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES EDGAR STOVER</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>February 13, 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1870</u>	
9. AGE last birthday: <u>85</u> yrs.		10. DATE OF BIRTH: <u>Sept. 20, 1871</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Supervisor-retired</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Steel mfg. co.</u>			
13. FATHER'S NAME: <u>Isaac Stover</u>				14. MOTHER'S MAIDEN NAME: <u>Eleanor Vance</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO: <u>None</u>			
17. INFORMANT & ADDRESS: <u>Richard Stover, Towson, Maryland</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 hour</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary Sclerosis</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1940</u> , 19 <u>40</u> , to <u>2-13</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1-31</u> , 19 <u>56</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>C. W. Peake</u>		ADDRESS <u>M D. 4508 Harford Rd</u>		DATE SIGNED <u>2-15-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 15, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Morland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 15, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		FUNERAL DIRECTOR <u>John Burns Sons</u>		ADDRESS <u>Towson, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 11

BUREAU V. S.

## 1399 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>ARBUTHUS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ARBUTHUS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5554 SOUTHWESTERN BLVD</u>		STREET ADDRESS (If rural give location) <u>5554 SOUTHWESTERN BLVD.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>CHARLES F. STRASSER</u>		OF DEATH: <u>FEB. 4</u> 19 <u>56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAY 12, 1895</u>
9. AGE last birthday: <u>60</u> yrs		10. DATE OF BIRTH: <u>90</u> Months <u>Days</u> <u>Hours</u> <u>Min.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LETTER CARRIER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>POST OFFICE</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-14-9468</u>	
17. INFORMANT & ADDRESS: <u>ANNA K. STRASSER 5554 SOUTHWESTERN BLVD</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>		38 days	
ANTECEDENT CAUSE (B) <u>Arterio Sclerosis -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from , 19 <u>36</u> , to <u>Feb 4</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>56</u> , and that death occurred at <u>6 - P M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frederick V. Beatter</u>		DATE SIGNED <u>M.D. 10 14</u>	
ADDRESS <u>Travis Ave - Balto - 26 36</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/7/56</u>	
NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 7, 1956</u>		REGISTRAR'S SIGNATURE <u>U. A. Hedrick</u>	
24. FUNERAL DIRECTOR. ADDRESS <u>Joseph J. Conlin, Jr. 1328 Sulphur Sp. Rd.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01537  
35

## 1559 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>				d. STREET ADDRESS <u>York Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert W. Strawbridge</u>				4. DATE OF DEATH <u>February 25, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1866</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>New Park, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Strawbridge</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Shirey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Simon Waltemyer, Parkton, Md. P.D.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 22, 1956</u> , to <u>Feb. 25, 1956</u> , that I last saw the deceased alive on <u>Feb. 25, 1956</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>2/26/56</u>			
NAME (Type) <u>Dr. A. M. France</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Febr 28 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Center Presby. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Park, York Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kerkentin</u> ADDRESS <u>New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>2/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Fulton</u>	

THE UNIVERSITY OF CHICAGO



CERTIFICATE OF DEATH

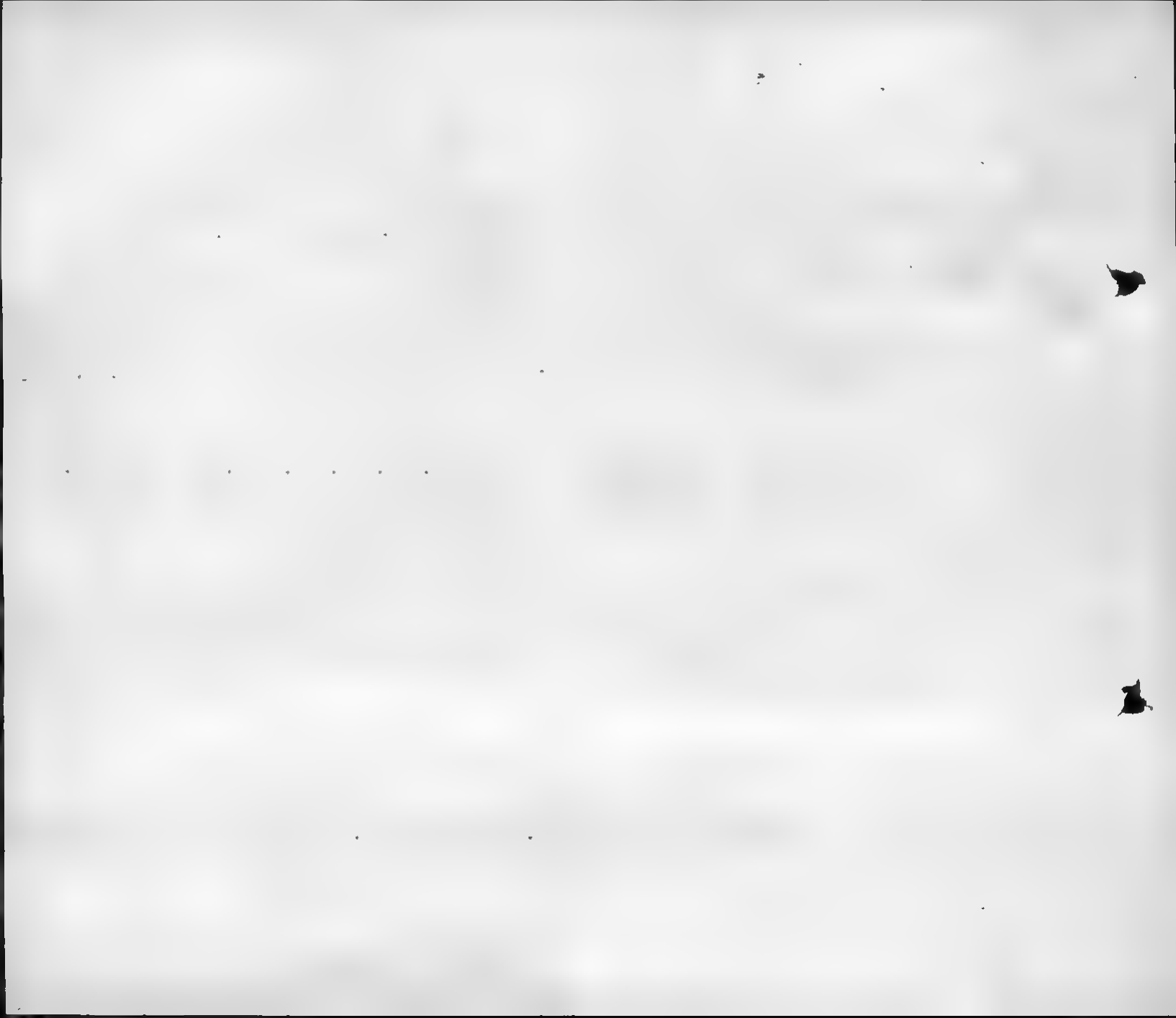
Reg. Dist. No. 44

1560

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FORT HOWARD</u>	MARYLAND LENGTH OF STAY (in this place) <u>93 Days</u>	STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GLEN BURNIE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>PT. PLEASANT, RT. 2, BOX 147</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>GEORGE J. STROHMER</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>FEBRUARY 19 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, W DOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 25, 1890</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper Boiler maker, Steel Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>John Strohmer</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Kunkle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-16-3548</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE (B) ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(A) <u>BILATERAL HYDRONEPHROSIS AND PYELONEPHRITIS</u> (B) <u>BENIGN PROSTATIC HYPERTROPHY</u> (C) <u>UNKNOWN</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2/13/56</u>		19B. MAJOR FINDINGS OF OPERATION <u>Transurethral Resection of Prostate</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>2</u> attended the deceased from <u>Nov. 18, 1955</u> to <u>Feb. 19, 1956</u> , that I last saw the deceased <u>xxxxxxxxxxxxxxxxxxxx</u> , and that death occurred at <u>2:50 P M.</u> from the causes and on the date stated above.			
SIGNATURE <u>D. D. MARK, M.D.</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-22-56</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>George Schwab</u>	
		FUNERAL DIRECTOR <u>George Schwab Funeral Home</u>	
		ADDRESS <u>2101 Frederick Ave., Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please wait the causes of death clearly and legibly.



1389

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD.</b> COUNTY <b>BALTO.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK (22)</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2604 YORKWAY</b>		STREET ADDRESS (If rural, give location) <b>2604 YORKWAY</b>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>ORVILLE</b> (Middle) <b>RUSSELL</b> (Last) <b>SWANN</b>		(Month) <b>2</b> (Day) <b>9</b> (Year) <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>16 MAY 1902</b>
9. AGE last birthday <b>53</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>W. VIRGINIA</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SWANN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-9489</b>	
17. INFORMANT <b>BESSIE B. SWANN</b>		<b>- WIDOW</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

**Coronary Occlusion**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

**2 hours**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**Feb 12 - 1956****William M. Kelly****North Park Building, Dundalk, Md.****DEL.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01540

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

Item 21 Film G193 2-29-56 ans  
Item 12, Film 200 2-27-56 et

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>FULLERTON</b> TOWN <b>FULLERTON</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MD.</b> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> TOWN <b>BALTIMORE</b> STREET ADDRESS (If rural, give location) <b>9223 BELAIR ROAD.</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>STANISLAWA-ELIZABETH-SZYNKIELEWSKI</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>2-14-1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year, give Months, Days, Hours, Min.) <b>75 yrs.</b>
10. FATHER'S NAME		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		13. SOCIAL SECURITY NO.	
14. MOTHER'S MAIDEN NAME <b>UNK.</b>		15. INFORMANT AND ADDRESS <b>John C. Dykema 7527 Belair Rd Baltimore Md</b>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>5 wks.</b>
Immediate cause (a) <b>Pulmonary Embolism</b>		
Antecedent cause(s) (b) <b>Inter trochanteric fracture at hips</b>		
(c) <b>resulting in phlebotomias</b>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>10 Jan. 56</b>	19b. MAJOR FINDINGS OF OPERATION <b>Fractured - Inter trochanteric fracture</b>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <b>Accident</b>	PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b>
22. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Jan 9 56 7a m.</b>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR? <b>Slip and fall down on stairs</b>	

22. I hereby certify that I attended the deceased from **9 Jan, 1956**, to **14 Feb, 1956**, that I last saw the deceased alive on **14 Feb, 1956**, and that death occurred at **8:30 A.M.**, from the causes and on the date stated above.

SIGNATURE <b>John C. Dykema</b>		ADDRESS <b>7527 Belair Rd Baltimore Md</b>		DATE SIGNED <b>2/15/56</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>2/17/56</b>	NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEM.</b>		LOCATION (City, town, or county) (State) <b>BALTIMORE</b>	
DATE REC'D BY LOCAL REG. <b>2-15-56</b>	REGISTRAR'S SIGNATURE <b>John C. Dykema</b>	24. FUNERAL DIRECTOR <b>Fred W. Ozagowski</b>		ADDRESS <b>1930 Eastman Ave.</b>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1562

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town Jones Creek</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Town Jones Creek</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7402 Hammond Road</u>		STREET ADDRESS (If rural give location) <u>7402 Hammond Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY E. TRACEY</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Feb. 8, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 27, 1900</u>
9. AGE last birthday: <u>56</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Doster</u>		14. MOTHER'S MAIDEN NAME: <u>Gillard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Joseph A. Tracey 7402 Hammond Road.</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
425.0 Immediate cause (a) ... <u>Coronary Thrombosis</u>		3 months	
Antecedent causes (b) ... <u>Hypertensive Arteriosclerosis Heart Disease</u>		?	
(c) ... <u>Bronchial Asthma</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 25, 1955</u> , to <u>Feb. 8, 1956</u> , that I last saw the deceased alive on <u>Feb. 2, 1956</u> , and that death occurred at <u>9:00 PM. 2/8/56</u> from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>David Owens M.D.</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Oak Lawn</u>	<u>Colgate, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 9, 1956</u>		24. FUNERAL DIRECTOR <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EB 10 1905



**1** **TO ATTENDING PHYSICIAN & HOSPITAL:** The law requires that the death certificate be secured within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS 115C 1-51 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1563 **CERTIFICATE OF DEATH**

01542

Reg. Dist. No. 35

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <i>Parkton</i>		<i>10 yrs</i>		TOWN <i>Parkton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>RICHARD</i> (First) <i>TRACY</i> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <i>Feb.</i> (Day) <i>27</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Widowed</i>	<b>8. DATE OF BIRTH</b> <i>Jan 28-1875</i>		<b>9. AGE last birthday</b> <i>81</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Farm.</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>md</i>		<b>12. CITIZEN OF WHAT COUNTRY</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Jacob Tracey</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Martha Eggling</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>no</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs Ralph Garrett, Parkton md</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from Feb. 20, 1956, to Feb. 23, 1956, that I last saw the deceased alive on Feb. 23, 1956, and that death occurred at 8 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>C. M. France</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Parkton md</i>		<b>DATE SIGNED</b> <i>2/23/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>Feb 27/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>St Abrahams Luth</i>		<b>LOCATION</b> (City, town, or county) <i>Balto Co md</i> (State)	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mrs Howard S. Maxine</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Edw C Tipton</i>		<b>ADDRESS</b> <i>Hampstead md</i>	
<b>DATE</b> <i>2-28-56</i>							

BUCKEY A. F.

1948

1948  
JAN 15  
1948

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01543

## 1564 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Freeland</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Freeland</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>Michalina</b>	(Middle) <b>R.</b>	(Last) <b>Trczinski (Taylor)</b>
4. DATE OF DEATH	(Month) <b>Feb.</b>	(Day) <b>2</b>	(Year) <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 1884</b>
9. AGE last birthday <b>71</b> yrs.		10. If under 1 year: Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ratajizak</b>		14. MOTHER'S MAIDEN NAME <b>Ida</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-0429A</b>	
17. INFORMANT AND ADDRESS <b>Mrs Marie Froelich</b>		<b>Freeland, Maryland</b>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Cerebral Hemorrhage**

INTERVAL BETWEEN ONSET AND DEATH

**10 days**

Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Arteriosclerosis**

**10 years**

(c)

#### 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

**Rheumatoid Arthritis**

**15 years**

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

**none**

**none**

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 23, 1956**, to **Feb 1, 1956**, that I last saw the deceased

alive on **Feb 1, 1956**, and that death occurred at **3:00 p.m.** from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Louis Schatanoff M.D.**

**New Freedom, Pa.**

**2/2/56**

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**Lilly & Zeiler Inc., 403 S. Wolfe St.**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1. 1. 1.



CERTIFICATE OF DEATH

Reg. Dist. No.

1565

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Overlea</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Overlea</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7 Fuller Ave.</b>		STREET ADDRESS (If rural give location) <b>7 Fuller Ave.</b>	
3. NAME OF DECEASED: (Type or Print) <b>Burleigh E. Turner</b>		4. DATE (Month) (Day) (Year) OF DEATH <b>Feb. 26, 1956</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>Married</b>	8. DATE OF BIRTH <b>Dec. 14, 1890</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
13. FATHER'S NAME: <b>Unknown</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT & ADDRESS: <b>216-09-8274 (Wife) 7 Fuller Ave.</b>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Coronary thrombosis</b>		<b>10 days</b>	
ANTECEDENT CAUSE (B) <b>Arteriosclerotic coronary</b>		<b>2 yrs.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <b>Heart disease</b>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY: YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 20, 1956</b> to <b>7 Feb, 1956</b> that I last saw the deceased alive on <b>Feb 25</b> 19 <b>56</b> and that death occurred at <b>8:30 PM</b> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 28, 56</b>	
NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		LOCATION (City or town, or county) <b>Balto. Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2-22-56</b>		REGISTRAR'S SIGNATURE <b>D. W. Kedgley</b>	
24. FUNERAL DIRECTOR <b>Paul A. Heemann</b>		ADDRESS <b>6067 Harford Rd.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1566

02505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|------------------------------------------|-------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                   |  | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                             |  |                                          |                                                                                     |
| COUNTY <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | MARYLAND                                                                                                          |  | STATE <b>Md.</b>                                                                   |  | COUNTY                                   |                                                                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN                                                                                                                                                                                                                                                                                                                                                                     |  | LENGTH OF STAY<br>(in this place)                                                                                 |  | CITY (If outside corporate limits write RURAL and give nearest town)<br>OR<br>TOWN |  |                                          |                                                                                     |
| HOSPITAL OR<br>INSTITUTION OR<br>STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  | STREET ADDRESS<br>(If rural, give location)                                        |  |                                          |                                                                                     |
| 3. NAME OF DECEASED:<br>(Type or Print)                                                                                                                                                                                                                                                                                                                                                                                                                 |  | (First)                                                                                                           |  | (Middle)                                                                           |  | (Last)                                   |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | <b>Unidentified Newborn</b>                                                                                       |  |                                                                                    |  |                                          |                                                                                     |
| 4. DATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | (Month)                                                                                                           |  | (Day)                                                                              |  | (Year)                                   |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | <b>2</b>                                                                                                          |  | <b>1</b>                                                                           |  | <b>19 56</b>                             |                                                                                     |
| 5. SEX:                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. COLOR OR RACE:                                                                                                 |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):                                  |  | 8. DATE OF BIRTH:                        |                                                                                     |
| <b>Female</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>White</b>                                                                                                      |  |                                                                                    |  |                                          |                                                                                     |
| 9. AGE last birthday:                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | IF UNDER 1 YEAR                                                                                                   |  | IF UNDER 24 HRS.                                                                   |  |                                          |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Months                                                                                                            |  | Days                                                                               |  | Hours Min.                               |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):                                                                                                                                                                                                                                                                                                                                                               |  | 10b. KIND OF BUSINESS OR INDUSTRY:                                                                                |  | 11. BIRTHPLACE (State or foreign country):                                         |  | 12. CITIZEN OF WHAT COUNTRY?             |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 13. FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                   |  | 14. MOTHER'S MAIDEN NAME:                                                          |  |                                          |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)                                                                                                                                                                                                                                                                                                                                                                                          |  | (If Yes, give war or dates of service)                                                                            |  | 16. SOCIAL SECURITY No.:                                                           |  | 17. INFORMANT & ADDRESS:                 |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                   |  |                                                                                    |  |                                          | INTERVAL BETWEEN ONSET AND DEATH                                                    |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| Immediate cause (a) ... <b>Anoxia secondary to placenta praevia.</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| Antecedent cause(s) (b) ...                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| Diseases or conditions, if any, giving rise to the above cause DUE TO                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| stating underlying cause last (c)                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 19a. DATE OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 19b. MAJOR FINDING OF OPERATION:                                                                                  |  |                                                                                    |  |                                          | 20. AUTOPSY?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                       |  | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY                                            |  | 21c. (City or town; (County) (State)                                               |  |                                          |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                                                                                                                                                                                                         |  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                                                         |  |                                          |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | M. D.                                                                                                             |  | DATE SIGNED                                                                        |  |                                          |                                                                                     |
| <i>Paul F. Mc...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                   |  | <b>2/2/56</b>                                                                      |  |                                          |                                                                                     |
| 23. BURIAL, CREMATION, REMOVAL (Specify):                                                                                                                                                                                                                                                                                                                                                                                                               |  | DATE THEREOF                                                                                                      |  | NAME OF CEMETERY OR CREMATORY                                                      |  | LOCATION (City, town, or county) (State) |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |
| DATE REC'D BY LOCAL REG.                                                                                                                                                                                                                                                                                                                                                                                                                                |  | REGISTRAR'S SIGNATURE                                                                                             |  | 24. FUNERAL DIRECTOR                                                               |  | ADDRESS                                  |                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                   |  |                                                                                    |  |                                          |                                                                                     |

MARGIN RESERVED FOR BINNING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



edt



1567

CERTIFICATE OF DEATH

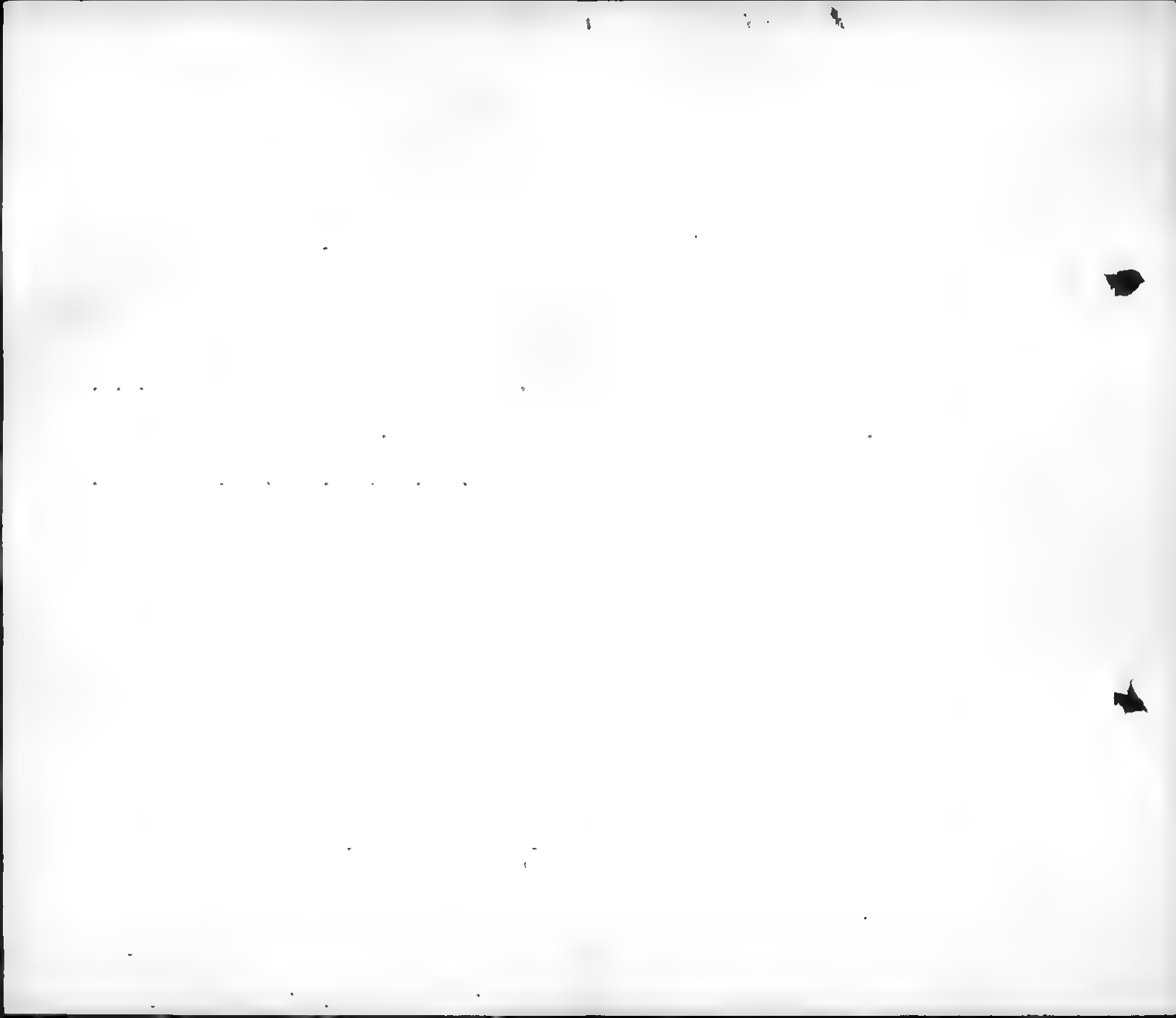
Reg. Dist. No.

44

|                                                                                                                                                                                                   |                                                 |                                                                                                      |                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------------|----------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                 |                                                 | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                               |                                  |
| COUNTY <b>Baltimore</b>                                                                                                                                                                           | MARYLAND                                        | STATE <b>Maryland</b>                                                                                | COUNTY                           |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>Fort Howard</b>                                                                                            | LENGTH OF STAY (in this place)<br><b>9 Days</b> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR<br>TOWN <b>Baltimore</b> |                                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>                                                                                                                 |                                                 | STREET ADDRESS (If rural give location)<br><b>7913 E. 30th Street</b>                                |                                  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>PERCY (NMI) URIE</b>                                                                                                                           |                                                 | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <b>February 25 19 56</b>                                   |                                  |
| 5. SEX: <b>Male</b>                                                                                                                                                                               | 6. COLOR OR RACE: <b>White</b>                  | 7. SINGLE MARRIED, W. DOWED, DIVORCED, (Specify): <b>Married</b>                                     | 8. DATE OF BIRTH: <b>9/23/95</b> |
| 9. AGE last birthday: <b>60 yrs.</b>                                                                                                                                                              |                                                 | 10. IF UNDER 1 YEAR: Months Days Hours Mins.                                                         |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if <b>Painter Foreman</b> )                                                                                       |                                                 | 10B. KIND OF BUSINESS OR INDUSTRY: <b>Gas &amp; Electric Co.</b>                                     |                                  |
| 11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>                                                                                                                             |                                                 | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                                           |                                  |
| 13. FATHER'S NAME: <b>Samuel H. Urie</b>                                                                                                                                                          |                                                 | 14. MOTHER'S MAIDEN NAME: <b>Annie V. Downey</b>                                                     |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes WW-I</b>                                                                             |                                                 | 16. SOCIAL SECURITY NO. <b>212-05-5133</b>                                                           |                                  |
| 17. INFORMANT & ADDRESS: <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>                                                                                                                       |                                                 |                                                                                                      |                                  |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                         |                                                 |                                                                                                      |                                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                |                                                 | INTERVAL BETWEEN ONSET AND DEATH                                                                     |                                  |
| IMMEDIATE CAUSE (A) <b>APLASTIC ANEMIA</b>                                                                                                                                                        |                                                 | UNKNOWN                                                                                              |                                  |
| ANTECEDENT CAUSE (B) DUE TO                                                                                                                                                                       |                                                 |                                                                                                      |                                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO                                                                                          |                                                 |                                                                                                      |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                              |                                                 |                                                                                                      |                                  |
| 19A. DATE OF OPERATION: <b>2</b>                                                                                                                                                                  |                                                 | 19B. MAJOR FINDINGS OF OPERATION                                                                     |                                  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                  |                                                 |                                                                                                      |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                  |                                                 | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                               |                                  |
| 21C. WHERE DID (City or town) (County) (State)                                                                                                                                                    |                                                 | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>                                         |                                  |
| 21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                            |                                                 | 21F. HOW DID INJURY OCCUR?                                                                           |                                  |
| 22. I hereby certify that I attended the deceased from <b>Feb. 16, 1956</b> , to <b>Feb. 25, 1956</b> , and that death occurred at <b>8:25 PM</b> , from the causes and on the date stated above. |                                                 |                                                                                                      |                                  |
| SIGNATURE <b>D. CARK</b>                                                                                                                                                                          |                                                 | ADDRESS <b>VAH, Fort Howard, Md.</b>                                                                 |                                  |
| DATE SIGNED                                                                                                                                                                                       |                                                 |                                                                                                      |                                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                            |                                                 | DATE THEREOF <b>2-29-56</b>                                                                          |                                  |
| NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>                                                                                                                                           |                                                 | LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>                                       |                                  |
| DATE REC'D BY LOCAL REGISTRAR <b>4/21/56</b>                                                                                                                                                      |                                                 | REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>                                                           |                                  |
| 24. FUNERAL DIRECTOR <b>Wm. Cook-Blight, Inc.</b>                                                                                                                                                 |                                                 | ADDRESS <b>6009 Harford Rd. Baltimore, Md.</b>                                                       |                                  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1568

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

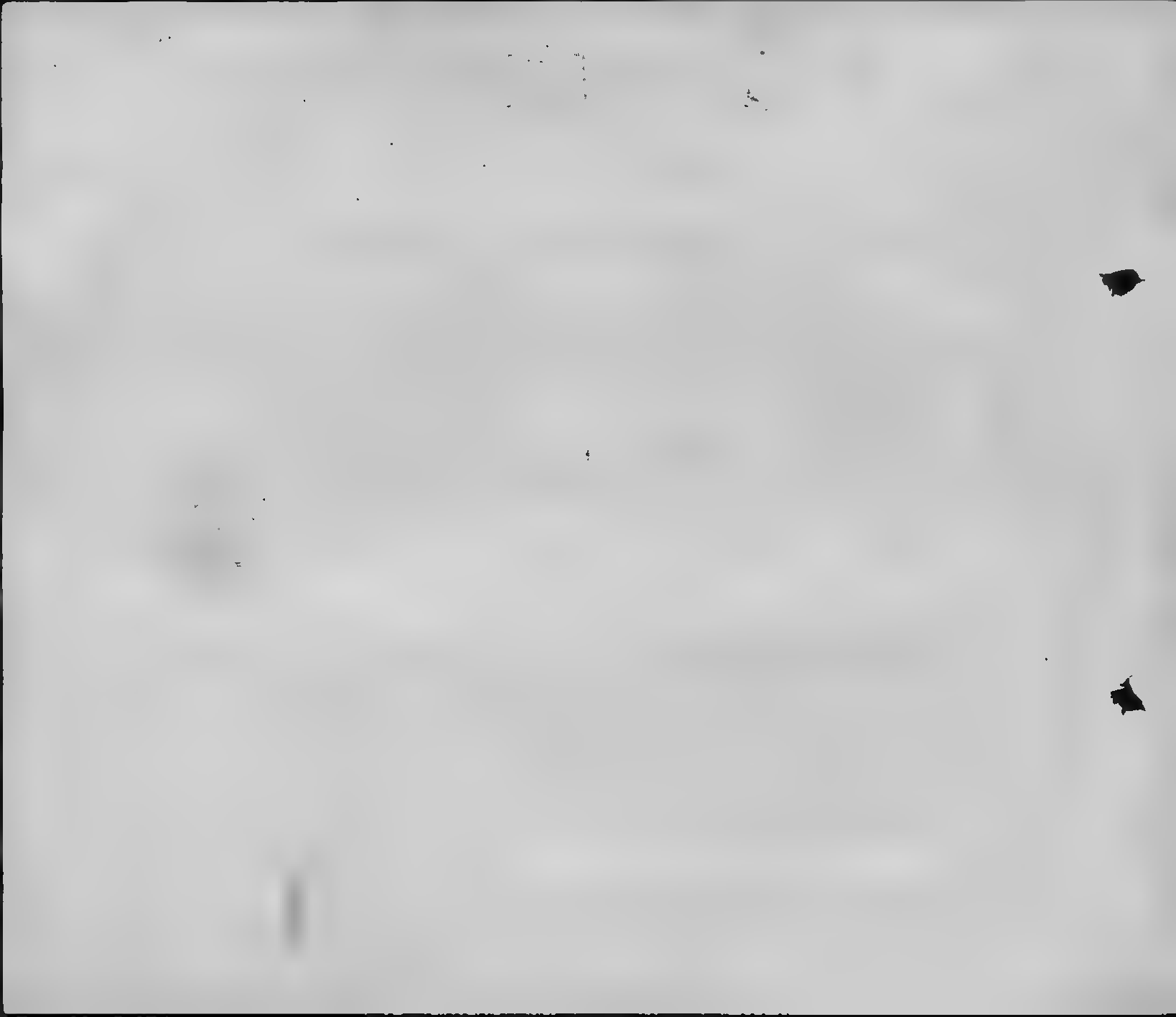
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01547

Reg. Dist.

No. *44*

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| <b>1. PLACE OF DEATH:</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                          |                                                                                                                                                                                                     |                                                  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>                                                                 |                                             |                                                                      |                                                                                            |
| COUNTY <i>Baltimore</i>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                          | MARYLAND                                                                                                                                                                                            |                                                  | STATE <i>Md.</i>                                                                                              |                                             | COUNTY                                                               |                                                                                            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>TOWN <i>Sharrows Point</i>                                                                                                                                                                                                                                                                                                                                      |                                          | LENGTH OF STAY (in this place)<br><i>2 Hours</i>                                                                                                                                                    |                                                  | CITY (If outside corporate limits write RURAL and give nearest town)<br>OR TOWN <i>Balto.</i> <i>7 Months</i> |                                             |                                                                      |                                                                                            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Beth Steel Hospital</i>                                                                                                                                                                                                                                                                                                                                                                        |                                          |                                                                                                                                                                                                     |                                                  | STREET ADDRESS (If rural, give location)<br><i>301 S. Norris St.</i>                                          |                                             |                                                                      |                                                                                            |
| <b>3. NAME OF DECEASED:</b> (First) <i>ELLSWORTH</i> (Middle) <i>M.</i> (Last) <i>VASS</i>                                                                                                                                                                                                                                                                                                                                                  |                                          |                                                                                                                                                                                                     |                                                  | <b>4. DATE OF DEATH</b> (Month) <i>2/14/56</i> (Day) <i>19</i> (Year)                                         |                                             |                                                                      |                                                                                            |
| <b>5. SEX:</b><br><i>Male</i>                                                                                                                                                                                                                                                                                                                                                                                                               | <b>6. COLOR OR RACE:</b><br><i>White</i> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED:</b><br><i>MARRIED</i>                                                                                                                                     | <b>8. DATE OF BIRTH:</b><br><i>MAY 31 - 1925</i> |                                                                                                               | <b>9. AGE last birthday:</b> <i>30</i> yrs. |                                                                      | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.                                           |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work, if any, even if retired): <i>TRUCK DRIVER</i>                                                                                                                                                                                                                                                                                                                                              |                                          | <b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <i>CONSTRUCTION Co</i>                                                                                                                                    |                                                  | <b>11. BIRTHPLACE</b> (State or foreign country): <i>OSWALD W. VA</i>                                         |                                             | <b>12. CITIZEN OF WHAT COUNTRY?</b>                                  |                                                                                            |
| <b>13. FATHER'S NAME:</b><br><i>William P. Vass</i>                                                                                                                                                                                                                                                                                                                                                                                         |                                          |                                                                                                                                                                                                     |                                                  | <b>14. MOTHER'S MAIDEN NAME:</b><br><i>EVELYN R. TONEY</i>                                                    |                                             |                                                                      |                                                                                            |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <i>YES</i>                                                                                                                                                                                                                                                                                                                                                            |                                          | <b>16. SOCIAL SECURITY No.:</b> <i>WW-436-76-4890</i>                                                                                                                                               |                                                  | <b>17. INFORMANT &amp; ADDRESS:</b><br><i>MANOES R. VASS 301 S. Norris St</i>                                 |                                             |                                                                      |                                                                                            |
| <b>18. MEDICAL CERTIFICATION</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                                    |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>                                                                                                                                                                                                                                                                                                                                                                                 |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| Immediate cause (a) ... <i>Arteriosclerotic heart disease</i>                                                                                                                                                                                                                                                                                                                                                                               |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| Antecedent cause(s) (b) ...                                                                                                                                                                                                                                                                                                                                                                                                                 |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| Diseases or conditions, if any, giving rise to the above cause DUE TO                                                                                                                                                                                                                                                                                                                                                                       |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| stating underlying cause last (c)                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>                                                                                                                                                                                                                                                                                                                |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| <b>19a. DATE OF OPERATION:</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                                          | <b>19b. MAJOR FINDING OF OPERATION:</b>                                                                                                                                                             |                                                  |                                                                                                               |                                             |                                                                      | <b>20. AUTOPSY?</b><br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| <b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                     |                                          | <b>21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY</b>                                                                                                                       |                                                  | <b>21c. (City or town) (County) (State)</b>                                                                   |                                             |                                                                      |                                                                                            |
| <b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                          | <b>21e. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                    |                                                  | <b>21f. HOW DID INJURY OCCUR?</b>                                                                             |                                             |                                                                      |                                                                                            |
| <b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b> |                                          |                                                                                                                                                                                                     |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| SIGNATURE <i>B. Fisher</i>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                          | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>2/14/56</i><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |                                                  |                                                                                                               |                                             |                                                                      |                                                                                            |
| <b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <i>BURIAL</i>                                                                                                                                                                                                                                                                                                                                                                              |                                          | <b>DATE THEREOF</b> <i>Feb 17 - 1956</i>                                                                                                                                                            |                                                  | <b>NAME OF CEMETERY OR CREMATORY</b> <i>TONEY CEMETERY</i>                                                    |                                             | <b>LOCATION (City, town, or county) (State)</b> <i>BECKLEY W. VA</i> |                                                                                            |
| <b>DATE REC'D BY LOCAL REG</b> <i>2-15-56</i>                                                                                                                                                                                                                                                                                                                                                                                               |                                          | <b>REGISTRAR'S SIGNATURE</b> <i>L</i>                                                                                                                                                               |                                                  | <b>2. FUNERAL DIRECTOR</b> <i>Harry B. M. Walters</i>                                                         |                                             | <b>ADDRESS</b> <i>PRA H &amp; Stricker Sts</i>                       |                                                                                            |



01548

STATE DEPARTMENT OF HEALTH

MARYLAND

1569

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

|                                                                                                                                                                                                                                                                  |                                                                                                   |                                                                                         |                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND                                                                                                                                                                                                            |                                                                                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u>  |                                                                          |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>                                                                                                                                                                          |                                                                                                   | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> |                                                                          |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1703 Kentistown Rd.</u>                                                                                                                                                                                             |                                                                                                   | STREET ADDRESS (If rural, give location) <u>1703 Kentistown Rd.</u>                     |                                                                          |
| 3. NAME OF DECEASED<br>(Type or Print) <u>DEIDHINE ELIZABETH VAUGHN</u>                                                                                                                                                                                          |                                                                                                   | 4. DATE OF DEATH<br>(Month) <u>11</u> (Day) <u>11</u> (Year) <u>1956</u>                |                                                                          |
| 5. SEX <u>Female</u>                                                                                                                                                                                                                                             | 6. COLOR OR RACE <u>White</u>                                                                     | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>                         | 8. DATE OF BIRTH <u>1922</u>                                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                                                                                                                                                      |                                                                                                   | 10b. KIND OF BUSINESS OR INDUSTRY                                                       | 9. AGE last birthday <u>34</u> yrs. If under 1 year Mon. Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country)                                                                                                                                                                                                                        |                                                                                                   | 12. CITIZEN OF WHAT COUNTRY?                                                            |                                                                          |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                |                                                                                                   | 14. MOTHER'S MAIDEN NAME                                                                |                                                                          |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If year, give war or dates of service <u>None</u>                                                                                                                                              |                                                                                                   | 16. SOCIAL SECURITY NO. <u>219-28-9073</u>                                              |                                                                          |
| 17. INFORMANT AND ADDRESS <u>John B. ...</u>                                                                                                                                                                                                                     |                                                                                                   | 18. MEDICAL CERTIFICATION                                                               |                                                                          |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                              |                                                                                                   | INTERVAL BETWEEN ONSET AND DEATH                                                        |                                                                          |
| Immediate cause (a) <u>Cancer</u>                                                                                                                                                                                                                                |                                                                                                   |                                                                                         |                                                                          |
| Antecedent cause(s) (b) <u>None</u>                                                                                                                                                                                                                              |                                                                                                   |                                                                                         |                                                                          |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>                                                                                                                                                 |                                                                                                   |                                                                                         |                                                                          |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                              |                                                                                                   |                                                                                         |                                                                          |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                           | 19b. MAJOR FINDINGS OF OPERATION                                                                  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>                   |                                                                          |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)                                                                                                                                                                                                                          | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY                                 | (CITY OR TOWN)                                                                          | (COUNTY) (STATE)                                                         |
| TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                       | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?                                                                   |                                                                          |
| 22. I hereby certify that I attended the deceased from <u>June 10, 1955</u> , to <u>June 17, 1956</u> , that I last saw the deceased alive on <u>June 17, 1956</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above. |                                                                                                   |                                                                                         |                                                                          |
| SIGNATURE <u>[Signature]</u> (Degree or title)                                                                                                                                                                                                                   |                                                                                                   | ADDRESS <u>[Address]</u> DATE SIGNED <u>[Date]</u>                                      |                                                                          |
| 23. BURIAL, CREMATION REMOVAL (Specify)                                                                                                                                                                                                                          | DATE                                                                                              | NAME OF CEMETERY OR CREMATORY                                                           | LOCATION (City, town, or county) (State)                                 |
| <u>Burial</u>                                                                                                                                                                                                                                                    | <u>Feb. 18, 1956</u>                                                                              | <u>Cator's Baptist Cemetery</u>                                                         | <u>Lutherville, Balto. Co., Md.</u>                                      |
| DATE REC'D BY LOCAL REG.                                                                                                                                                                                                                                         | REGISTRAR'S SIGNATURE <u>[Signature]</u>                                                          | 7. GENERAL DIRECTOR <u>[Signature]</u>                                                  | ADDRESS <u>Towson, Maryland</u>                                          |

MARGIN RESERVED FOR BINDING

RECEIVED  
FEB 21 1955  
U. S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

01549

1570 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

|                                                                                                               |                                  |                                                                                        |                                                                                      |
|---------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore</u> MARYLAND                                                         |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY                  |                                                                                      |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>                        |                                  | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |                                                                                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1559 Homestead Street #18</u>                                    |                                  | STREET ADDRESS (If rural, give location) <u>1559 Homestead Street #18</u>              |                                                                                      |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Mrs. Josephine B. Walther</u>                                       |                                  | 4. DATE OF DEATH<br>(Month) <u>February</u> (Day) <u>18th</u> (Year) <u>1956</u>       |                                                                                      |
| 5. SEX<br><u>female</u>                                                                                       | 6. COLOR OR RACE<br><u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>                        | 8. DATE OF BIRTH<br><u>Mar. 1, 1899</u>                                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>at home</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                      | 9. AGE last birthday<br><u>56</u> yrs. If under 1 year Months Days If under 24 h. m. |
| 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u>                                       |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                             |                                                                                      |
| 13. FATHER'S NAME<br><u>Unknown (Stein)</u>                                                                   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                                             |                                                                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)      |                                  | 16. SOCIAL SECURITY NO.                                                                |                                                                                      |
| 17. INFORMANT AND ADDRESS<br><u>Mr. August Michael Walther, 1559 Homestead</u>                                |                                  |                                                                                        |                                                                                      |

18. MEDICAL CERTIFICATION

|                                                                                                                                |  |                                  |
|--------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                            |  | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Heart failure</u>                                                                                       |  |                                  |
| Antecedent cause(s) (b) <u>Disease of conditions, if any, giving rise to the above cause stating the underlying cause last</u> |  |                                  |
| (c) <u></u>                                                                                                                    |  |                                  |

|                                                                                                                                     |                                                                                                   |                                                                          |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                                                                                   |                                                                          |
| 19a. DATE OF OPERATION                                                                                                              | 19b. MAJOR FINDINGS OF OPERATION                                                                  | 20. AUTOPSY?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.                                                                      | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)                                          |
| TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                          | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | HOW DID INJURY OCCUR?                                                    |

22. I certify, that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

|                                       |                                               |                                |                                          |
|---------------------------------------|-----------------------------------------------|--------------------------------|------------------------------------------|
| 19. INFORMATION<br>(Date, time, etc.) | DATE THEREOF                                  | NAME OF CEMETERY OR CREMATORY  | LOCATION (City, town, or county) (State) |
| <u>Burial</u>                         | <u>Feb. 21, 1956</u>                          | <u>Baltimore National Cem.</u> | <u>Baltimore, Maryland</u>               |
| DATE BY LOCAL REGISTRAR'S SIGNATURE   | 21. FUNERAL DIRECTOR                          |                                | ADDRESS                                  |
| <u>Feb 26, 1956</u>                   | <u>Leonard J. Ruck, 5305 Harford Road #14</u> |                                |                                          |

MARGIN RESERVED FOR BINING

USE WRITING FLUENTLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.





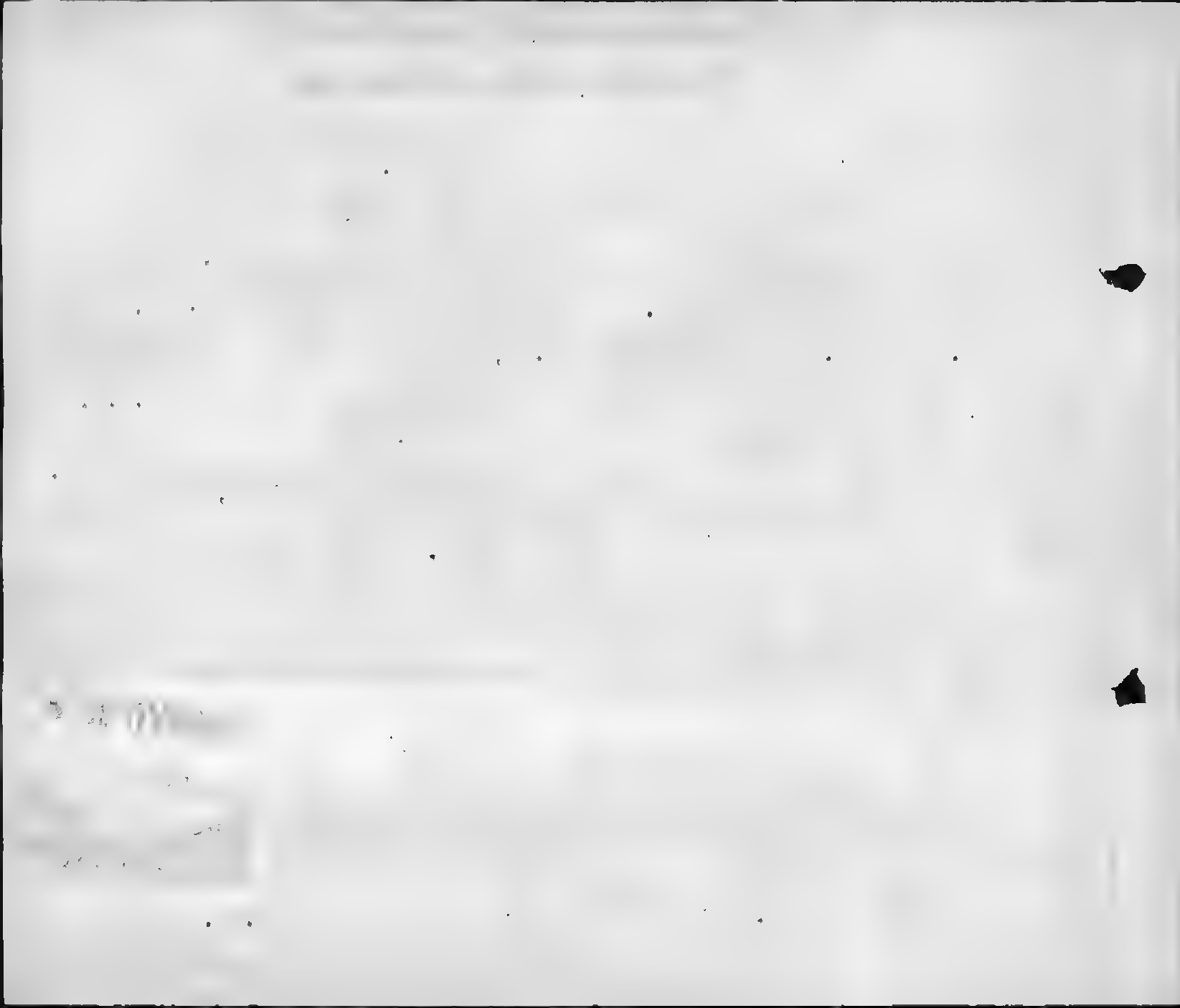
## 1400 CERTIFICATE OF DEATH

Reg. Dist. No. 47

|                                                                                                                                                                                                                                                                    |                               |                                                                            |                                          |                                                                                              |                                |                                                               |                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------|--------------------------------|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                                  |                               |                                                                            |                                          | 2. USUAL RESIDENCE (HOME) OF DECEASED                                                        |                                |                                                               |                                |
| COUNTY <u>Baltimore</u>                                                                                                                                                                                                                                            |                               | MARYLAND                                                                   |                                          | STATE <u>Md.</u>                                                                             |                                | COUNTY <u>C</u>                                               |                                |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Arbutus</u>                                                                                                                                                                       |                               | LENGTH OF STAY (In this place)                                             |                                          | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Arbutus</u> |                                |                                                               |                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1050 Downton Rd.</u>                                                                                                                                                                                                  |                               |                                                                            |                                          | STREET ADDRESS (If rural give location)<br><u>1050 Downton Rd.</u>                           |                                |                                                               |                                |
| 3. NAME OF DECEASED (Type or Print)<br>(First) <u>George</u> (Middle) <u>E.</u> (Last) <u>Ward</u>                                                                                                                                                                 |                               |                                                                            |                                          | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Feb. 4, 1956</u>                                 |                                |                                                               |                                |
| 5. SEX<br><u>M.</u>                                                                                                                                                                                                                                                | 6. COLOR OR RACE<br><u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Divorced</u>        | 8. DATE OF BIRTH<br><u>Jan. 29, 1898</u> | 9. AGE last birthday<br><u>58</u> yrs.                                                       | IF UNDER 1 YEAR<br>Months Days |                                                               | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Machinist</u>                                                                                                                                                    |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>B&amp;O Railroad</u>               |                                          | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                                 |                                | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                 |                                |
| 13. FATHER'S NAME<br><u>Thomas Ward</u>                                                                                                                                                                                                                            |                               |                                                                            |                                          | 14. MOTHER'S MAIDEN NAME<br><u>Laura</u>                                                     |                                |                                                               |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)                                                                                                                                                                                                    |                               | 16. SOCIAL SECURITY NO.                                                    |                                          | 17. INFORMANT & ADDRESS<br><u>Mrs Doris Ruediger, 1050 Downton Rd.</u>                       |                                |                                                               |                                |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                          |                               |                                                                            |                                          | INTERVAL BETWEEN ONSET AND DEATH                                                             |                                |                                                               |                                |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                 |                               |                                                                            |                                          |                                                                                              |                                |                                                               |                                |
| IMMEDIATE CAUSE (A) <u>Arteriosclerotic Encephalopathy</u>                                                                                                                                                                                                         |                               |                                                                            |                                          |                                                                                              |                                |                                                               |                                |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>with Cerebral Arteriosclerosis</u>                                                                                                                                                                                               |                               |                                                                            |                                          | <u>9 Months</u>                                                                              |                                |                                                               |                                |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)                                                                                                                                                           |                               |                                                                            |                                          |                                                                                              |                                |                                                               |                                |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Broncho pneumonia Bilateral</u>                                                                                                            |                               |                                                                            |                                          | <u>7 days</u>                                                                                |                                |                                                               |                                |
| 19a. DATE OF OPERATION<br><u>Dec. 1955</u>                                                                                                                                                                                                                         |                               | 19b. MAJOR FINDINGS OF OPERATION<br><u>Arteriosclerotic Encephalopathy</u> |                                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                                |                                                               |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                 |                               | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)     |                                          | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                 |                                |                                                               |                                |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                                                                      |                               | 21e. INJURY OCCURRED                                                       |                                          | 21f. HOW DID INJURY OCCUR?                                                                   |                                |                                                               |                                |
| 22. I hereby certify that I attended the deceased from <u>JANUARY 6, 1956</u> , to <u>FEBRUARY 4, 1956</u> , that I last saw the deceased alive on <u>Feb. 4, 1956</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above. |                               |                                                                            |                                          |                                                                                              |                                |                                                               |                                |
| SIGNATURE<br><u>Malvin N. Borden</u>                                                                                                                                                                                                                               |                               |                                                                            |                                          | ADDRESS (Street, city, town, state)<br><u>5000 Old Frederick Rd Balt 29</u>                  |                                |                                                               |                                |
| DATE SIGNED<br><u>2/7/56</u>                                                                                                                                                                                                                                       |                               |                                                                            |                                          |                                                                                              |                                |                                                               |                                |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                          |                               | DATE THEREOF<br><u>Feb. 8/56</u>                                           |                                          | NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park</u>                                          |                                | LOCATION (City, town, or county) (State)<br><u>Balto. Md.</u> |                                |
| 24. REC'D BY REGISTRAR<br><u>Dr. Geo. S. McLaughlin</u>                                                                                                                                                                                                            |                               | REGISTRAR'S SIGNATURE                                                      |                                          | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harry H. Witte</u>                                    |                                | ADDRESS<br><u>1101 Edmondson Ave.</u>                         |                                |

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01551

1571

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

|                                                                                                                                                                                                                                                                    |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------|-----------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                                                 |                   |                                                                                                                                                          |                         | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                      |                        |                                                                                  |                             |
| COUNTY <u>Baltimore</u>                                                                                                                                                                                                                                            |                   | MARYLAND                                                                                                                                                 |                         | STATE <u>Maryland</u>                                                                       |                        | COUNTY <u>Baltimore</u>                                                          |                             |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)                                                                                                                                                                                           |                   | LENGTH OF STAY (in this place)                                                                                                                           |                         | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> |                        |                                                                                  |                             |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1836 Loch Shiel Road</u>                                                                                                                                                                                              |                   |                                                                                                                                                          |                         | STREET ADDRESS (If rural give location) <u>1836 Loch Shiel Road</u>                         |                        |                                                                                  |                             |
| 3. NAME OF DECEASED: (First) (Middle) (Last)                                                                                                                                                                                                                       |                   |                                                                                                                                                          |                         | 4. DATE (Month) (Day) (Year)                                                                |                        |                                                                                  |                             |
| <u>MAURICE HARDESTY WARD</u>                                                                                                                                                                                                                                       |                   |                                                                                                                                                          |                         | OF DEATH: <u>February 3, 1956</u>                                                           |                        |                                                                                  |                             |
| 5. SEX:                                                                                                                                                                                                                                                            | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):                                                                                                        | 8. DATE OF BIRTH:       | 9. AGE last birthday yrs.                                                                   | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days                                                            | IF UNDER 24 HRS. Hours Min. |
| <u>Male</u>                                                                                                                                                                                                                                                        | <u>White</u>      | <u>Married</u>                                                                                                                                           | <u>October 30, 1888</u> | <u>67</u>                                                                                   |                        |                                                                                  |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life.)                                                                                                                                                                                        |                   | 10B. KIND OF BUSINESS OR INDUSTRY:                                                                                                                       |                         | 11. BIRTHPLACE (State or foreign country):                                                  |                        | 12. CITIZEN OF WHAT COUNTRY?                                                     |                             |
| <u>Ice Dealer-retired</u>                                                                                                                                                                                                                                          |                   | <u>Self employed</u>                                                                                                                                     |                         | <u>Maryland</u>                                                                             |                        | <u>USA</u>                                                                       |                             |
| 13. FATHER'S NAME:                                                                                                                                                                                                                                                 |                   |                                                                                                                                                          |                         | 14. MOTHER'S MAIDEN NAME:                                                                   |                        |                                                                                  |                             |
| <u>Asa Ward</u>                                                                                                                                                                                                                                                    |                   |                                                                                                                                                          |                         | <u>Ida E. Hardesty</u>                                                                      |                        |                                                                                  |                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                              |                   | 16. SOCIAL SECURITY NO.                                                                                                                                  |                         | 17. INFORMANT & ADDRESS:                                                                    |                        |                                                                                  |                             |
| <u>No</u>                                                                                                                                                                                                                                                          |                   | <u>None</u>                                                                                                                                              |                         | <u>1836 Loch Shiel Rd., Mrs. Mattie P. Ward, Towson, Maryland</u>                           |                        |                                                                                  |                             |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                          |                   |                                                                                                                                                          |                         |                                                                                             |                        | INTERVAL BETWEEN ONSET AND DEATH                                                 |                             |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                 |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| IMMEDIATE CAUSE (A)                                                                                                                                                                                                                                                |                   |                                                                                                                                                          |                         |                                                                                             |                        | <u>72 hrs</u>                                                                    |                             |
| DUE TO <u>Cerebral Thrombosis</u>                                                                                                                                                                                                                                  |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| ANTECEDENT CAUSE (B)                                                                                                                                                                                                                                               |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| DUE TO <u>Generalized Arteriosclerosis</u>                                                                                                                                                                                                                         |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                                                                                                                                                      |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| DUE TO <u>Very premature for age</u>                                                                                                                                                                                                                               |                   |                                                                                                                                                          |                         |                                                                                             |                        | <u>6 yrs</u>                                                                     |                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                               |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| 19A. DATE OF OPERATION:                                                                                                                                                                                                                                            |                   |                                                                                                                                                          |                         | 19B. MAJOR FINDINGS OF OPERATION                                                            |                        |                                                                                  |                             |
|                                                                                                                                                                                                                                                                    |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                 |                   | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                                                                   |                         | 21C. WHERE DID (City or town) (County) (State)                                              |                        | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                             |
|                                                                                                                                                                                                                                                                    |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                    |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                         | 21F. HOW DID INJURY OCCUR?                                                                  |                        |                                                                                  |                             |
|                                                                                                                                                                                                                                                                    |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| 22. I hereby certify that I attended the deceased from <u>Aug. 1949</u> , to <u>February 1956</u> that I last saw the deceased alive on <u>February 3 1956</u> , and that death occurred at <u>5<sup>15</sup> M.</u> from the causes and on the date stated above. |                   |                                                                                                                                                          |                         |                                                                                             |                        |                                                                                  |                             |
| SIGNATURE                                                                                                                                                                                                                                                          |                   | ADDRESS                                                                                                                                                  |                         | DATE SIGNED                                                                                 |                        |                                                                                  |                             |
| <u>Charles F. O'Donnell</u>                                                                                                                                                                                                                                        |                   | <u>2501 Loch Rd. Towson Md</u>                                                                                                                           |                         | <u>4/5/56</u>                                                                               |                        |                                                                                  |                             |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                                           |                   | DATE THEREOF                                                                                                                                             |                         | NAME OF CEMETERY OR CREMATORY                                                               |                        | LOCATION (City, town, or county) (State)                                         |                             |
| <u>Burial</u>                                                                                                                                                                                                                                                      |                   | <u>Feb. 6, 1956</u>                                                                                                                                      |                         | <u>Prospect Hill Cemetery</u>                                                               |                        | <u>Towson, Maryland</u>                                                          |                             |
| DATE REC'D BY LOCAL REGISTRAR                                                                                                                                                                                                                                      |                   | REGISTRAR'S SIGNATURE                                                                                                                                    |                         | 24. FUNERAL DIRECTOR                                                                        |                        | ADDRESS                                                                          |                             |
| <u>2/7/56</u>                                                                                                                                                                                                                                                      |                   | <u>A. M. Bacon</u>                                                                                                                                       |                         | <u>John Burns' Sons, Towson, Maryland</u>                                                   |                        |                                                                                  |                             |

BUCHHEIM W. E.

PL 3

RECEIVED  
FEB 10 1968

INSTRUCTIONS

1  
TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

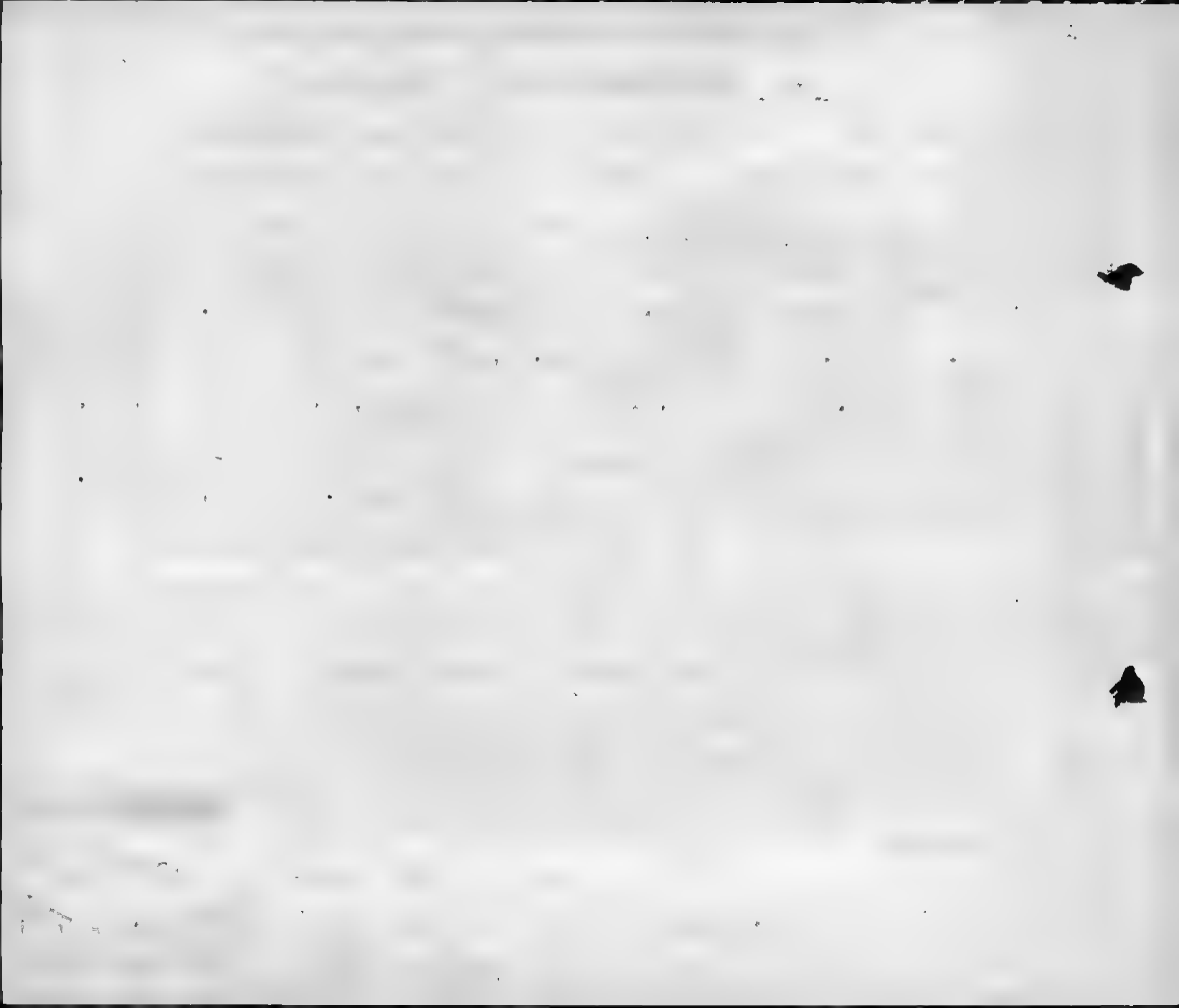
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1572

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|                                                                                                                                                                                                                                                                                  |                               |                                                                                                                                                          |                                          |                                                                                                          |                                        |                                                           |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------|-----------------------------------------------------------|--|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                                                |                               |                                                                                                                                                          |                                          | 2. USUAL RESIDENCE (HOME) OF DECEASED                                                                    |                                        |                                                           |  |
| COUNTY <u>Baltimore</u>                                                                                                                                                                                                                                                          |                               | MARYLAND                                                                                                                                                 |                                          | STATE <u>Md.</u>                                                                                         |                                        | COUNTY                                                    |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Catonsville</u>                                                                                                                                                                                 |                               | LENGTH OF STAY<br>(in this place)                                                                                                                        |                                          | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Owings Mills Md.</u> |                                        |                                                           |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>House In The Pines</u><br><u>16 Fusting Ave</u>                                                                                                                                                                                  |                               |                                                                                                                                                          |                                          | STREET ADDRESS<br><u>Owings Mills Md.</u>                                                                |                                        | (If rural give location)                                  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Grace E. Wareheim</u><br>(First) (Middle) (Last)                                                                                                                                                                                       |                               |                                                                                                                                                          |                                          | 4. DATE OF DEATH <u>Feb. 22 1956</u><br>(Month) (Day) (Year)                                             |                                        |                                                           |  |
| 5. SEX<br><u>F.</u>                                                                                                                                                                                                                                                              | 6. COLOR OR RACE<br><u>W.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>Married</u>                                                                                       | 8. DATE OF BIRTH<br><u>Aug. 15, 1874</u> |                                                                                                          | 9. AGE last birthday<br><u>81</u> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>H.W.</u>                                                                                                                                                                       |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>O.H.</u>                                                                                                         |                                          | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Md.</u>                                       |                                        | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>             |  |
| 13. FATHER'S NAME<br><u>John Walsh</u>                                                                                                                                                                                                                                           |                               |                                                                                                                                                          |                                          | 14. MOTHER'S MAIDEN NAME<br><u>Mary Tucker</u>                                                           |                                        |                                                           |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br>(If Yes, give war or dates of service)                                                                                                                                                                        |                               | 16. SOCIAL SECURITY NO.                                                                                                                                  |                                          | 17. INFORMANT & ADDRESS<br><u>Theodore E. Wareheim, Owings Mills Md.</u>                                 |                                        |                                                           |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                               |                               |                                                                                                                                                          |                                          | 18. MEDICAL CERTIFICATION                                                                                |                                        |                                                           |  |
| IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROTIC CEREBRO VASCULAR</u>                                                                                                                                                                                                                    |                               |                                                                                                                                                          |                                          | INTERVAL BETWEEN ONSET AND DEATH                                                                         |                                        |                                                           |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASE - CEREBRAL SCLEROSIS</u>                                                                                                                                                                                                               |                               |                                                                                                                                                          |                                          |                                                                                                          |                                        |                                                           |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>TERMINAL PNEUMONIA - UREMIA</u>                                                                                                                                      |                               |                                                                                                                                                          |                                          |                                                                                                          |                                        |                                                           |  |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.<br><u>HYPERTENSIVE HYPERTENSIS</u>                                                                                                                          |                               |                                                                                                                                                          |                                          |                                                                                                          |                                        |                                                           |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                           |                               | 19b. MAJOR FINDINGS OF OPERATION                                                                                                                         |                                          | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |                                        |                                                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                               |                               | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                                                                   |                                          | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                             |                                        |                                                           |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)                                                                                                                                                                                                                           |                               | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                          | 21f. HOW DID INJURY OCCUR?                                                                               |                                        |                                                           |  |
| 22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>2/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>56</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above. |                               |                                                                                                                                                          |                                          |                                                                                                          |                                        |                                                           |  |
| SIGNATURE <u>John H. Shaw</u>                                                                                                                                                                                                                                                    |                               | ADDRESS (Street, city, town, state) <u>M.D. 5800 Edmondson Ave</u>                                                                                       |                                          | DATE SIGNED <u>2/24/56</u>                                                                               |                                        |                                                           |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>                                                                                                                                                                                                                        |                               | DATE THEREOF<br><u>Feb. 25/56</u>                                                                                                                        |                                          | NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge</u>                                                      |                                        | LOCATION (City, town, or county)<br><u>Pikesville Md.</u> |  |
| 24. REC'D BY REGISTRAR<br><u>FFB 27 1956</u>                                                                                                                                                                                                                                     |                               | REGISTRAR'S SIGNATURE<br><u>V. E. Harry</u>                                                                                                              |                                          | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harry H. Witzke</u>                                               |                                        | ADDRESS<br><u>4101 Edmondson Ave</u>                      |  |



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01553

## 1573 CERTIFICATE OF DEATH

Reg. Dist. No. 38

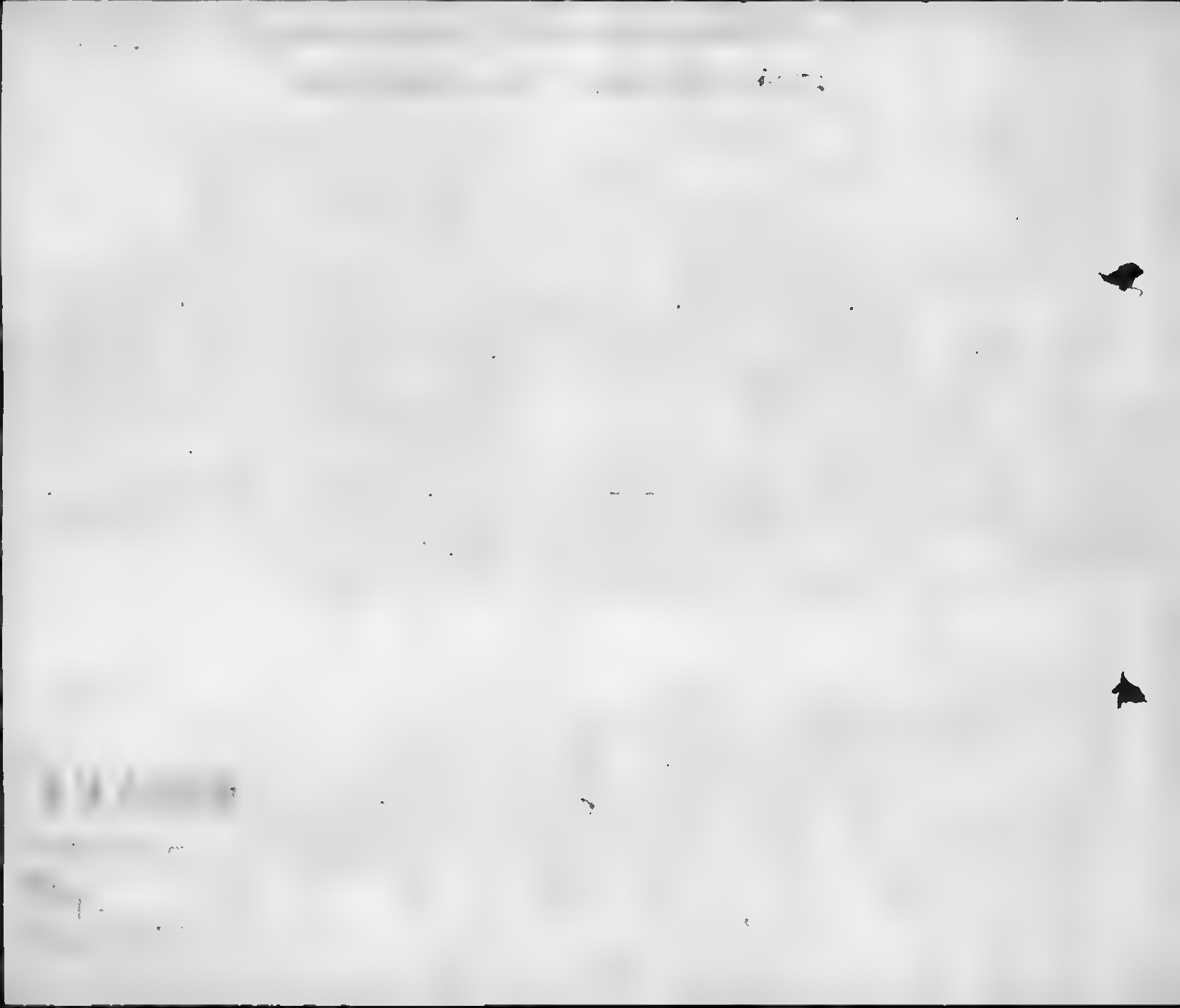
|                                                                                                                                                                                                                                                                               |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| 1. PLACE OF DEATH                                                                                                                                                                                                                                                             |  |                                                                                                        |  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |  |                                                                       |  |
| COUNTY <b>Baltimore</b>                                                                                                                                                                                                                                                       |  | MARYLAND                                                                                               |  | STATE <b>Maryland</b>                                                 |  | COUNTY <b>Baltimore</b>                                               |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                                                                                                                                                                                         |  | LENGTH OF STAY (In this place)                                                                         |  | CITY (If outside corporate limits, write RURAL and give nearest town) |  |                                                                       |  |
| TOWN <b>Parkville</b>                                                                                                                                                                                                                                                         |  |                                                                                                        |  | TOWN <b>Parkville</b>                                                 |  |                                                                       |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3011 Hiss Avenue</b>                                                                                                                                                                                                             |  |                                                                                                        |  | STREET ADDRESS (If rural give location) <b>3011 Hiss Avenue</b>       |  |                                                                       |  |
| 3. NAME OF DECEASED (Type or Print) <b>Mr. Lloyd A. Westley</b>                                                                                                                                                                                                               |  |                                                                                                        |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 1, 1956</b>             |  |                                                                       |  |
| 5. SEX <b>male</b>                                                                                                                                                                                                                                                            |  | 6. COLOR OR RACE <b>white</b>                                                                          |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>       |  | 8. DATE OF BIRTH <b>May 25, 1886</b>                                  |  |
|                                                                                                                                                                                                                                                                               |  |                                                                                                        |  | 9. AGE last birthday <b>69</b> yrs.                                   |  | IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool &amp; Dye Worker</b>                                                                                                                                                      |  |                                                                                                        |  | 10b. KIND OF BUSINESS OR INDUSTRY                                     |  | 11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                       |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
| 13. FATHER'S NAME <b>Henry Westley</b>                                                                                                                                                                                                                                        |  |                                                                                                        |  | 14. MOTHER'S MAIDEN NAME <b>Ida Raine</b>                             |  |                                                                       |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                        |  |                                                                                                        |  | 16. SOCIAL SECURITY NO. <b>212-10-9595</b>                            |  | 17. INFORMANT & ADDRESS <b>Mrs. Mildred Westley, 3011 Hiss Ave.</b>   |  |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                     |  |                                                                                                        |  |                                                                       |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b>                   |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                            |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
| A. IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b>                                                                                                                                                                                                                             |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
| B. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>arteriosclerotic CVD</b>                                                                                                                   |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
| C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)                                                                                                                                                      |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                                                        |  | 19b. MAJOR FINDINGS OF OPERATION                                                                       |  |                                                                       |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                              |  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)          |  |                                                                       |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)                                                                                                                                                                                                                        |  | 21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                                            |  |                                                                       |  |
| 22. I hereby certify that I attended the deceased from <b>2/1</b> , 19 <b>55</b> , to <b>2/1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>2/1</b> , 19 <b>56</b> , and that death occurred at <b>9:30</b> P.M. from the causes and on the date stated above. |  |                                                                                                        |  |                                                                       |  |                                                                       |  |
| SIGNATURE <b>Harold A. Grotz</b> M.D.                                                                                                                                                                                                                                         |  |                                                                                                        |  | ADDRESS (Street, city, town, state) <b>5100 Harford Rd</b>            |  | DATE SIGNED <b>2/2/56</b>                                             |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                                                                                                        |  | DATE THEREOF <b>Feb 4, 1956</b>                                                                        |  | NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>                |  | LOCATION (City, town, or county) <b>Baltimore, Md.</b>                |  |
| 24. REC'D BY REGISTRAR                                                                                                                                                                                                                                                        |  | REGISTRAR'S SIGNATURE <b>Dr. A. M. Bacon</b>                                                           |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>               |  | ADDRESS <b>5305 Harford Road #14</b>                                  |  |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The death copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been accepted by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 10M





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

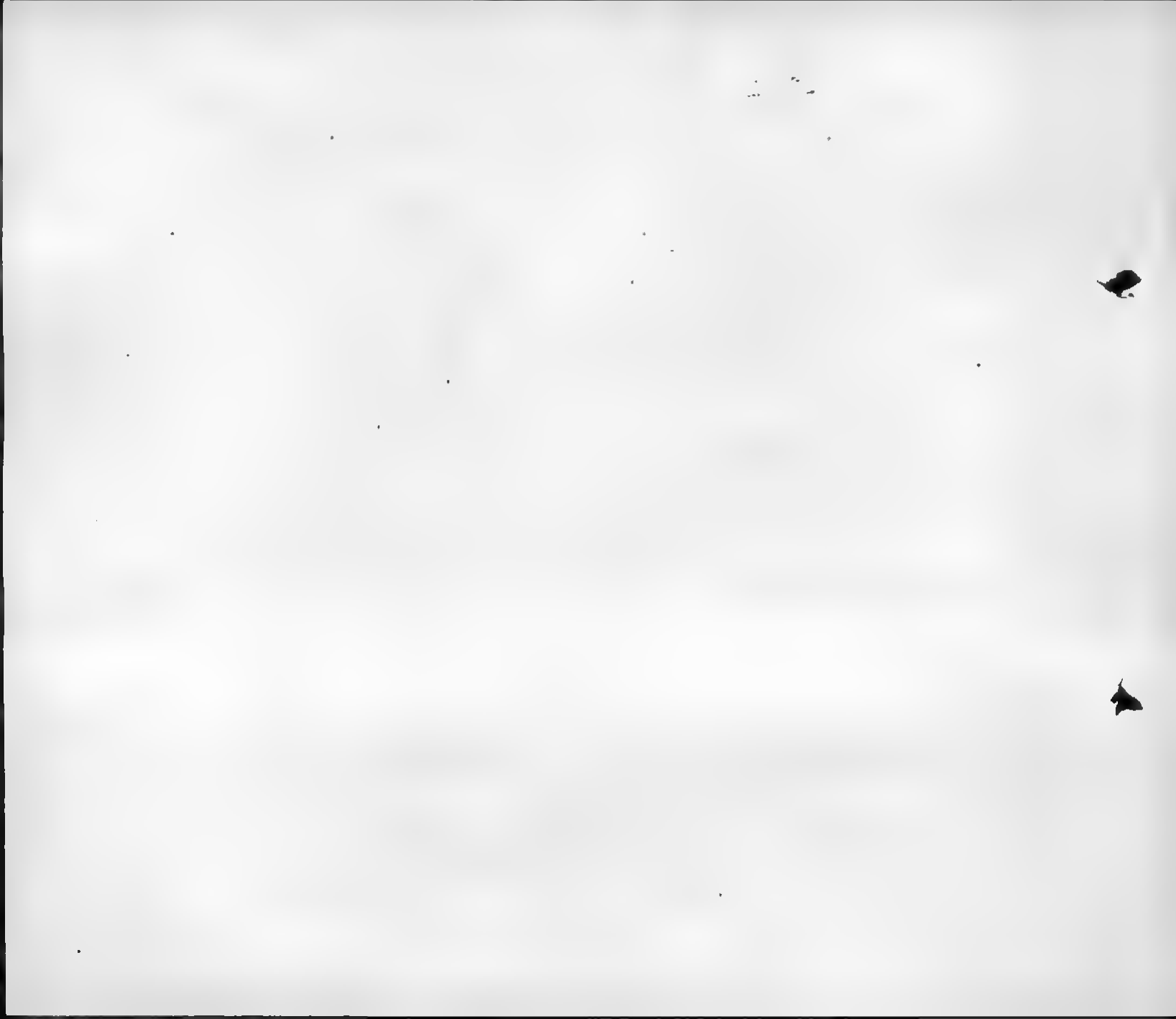
01554

1574

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                                                                |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------|-----------------|------------------------------------------------|------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                             |                   |                                                                                                                                                          |                     | 2. USUAL RESIDENCE (HOME) OF DECEASED.                                |                 |                                                |            |
| COUNTY <u>Balto.</u>                                                                                                                                                                                                                           |                   | MARYLAND                                                                                                                                                 |                     | STATE <u>Md.</u>                                                      |                 | COUNTY                                         |            |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                                                                                                                                                          |                   | LENGTH OF STAY (In this place)                                                                                                                           |                     | CITY (If outside corporate limits, write RURAL and give nearest town) |                 |                                                |            |
| TOWN <u>Towson</u>                                                                                                                                                                                                                             |                   |                                                                                                                                                          |                     | TOWNSHIP <u>Towson</u>                                                |                 |                                                |            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1718 Redwood Ave.</u>                                                                                                                                                                             |                   |                                                                                                                                                          |                     | STREET ADDRESS (If rural give location) <u>1718 Redwood Ave.</u>      |                 |                                                |            |
| 3. NAME OF DECEASED: (First) (Middle) (Last)                                                                                                                                                                                                   |                   |                                                                                                                                                          |                     | 4. DATE (Month) (Day) (Year)                                          |                 |                                                |            |
| <u>WILSON M. WHALEY</u>                                                                                                                                                                                                                        |                   |                                                                                                                                                          |                     | <u>Feb. 10, 1956</u>                                                  |                 |                                                |            |
| 5. SEX:                                                                                                                                                                                                                                        | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):                                                                                                        | 8. DATE OF BIRTH:   | 9. AGE last birthday                                                  | IF UNDER 1 YEAR | IF UNDER 24 HRS.                               |            |
| <u>male</u>                                                                                                                                                                                                                                    | <u>white</u>      | <u>married</u>                                                                                                                                           | <u>Aug. 9, 1894</u> | <u>61</u> yrs.                                                        | Months          | Days                                           | Hours Mln. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):                                                                                                                                                   |                   |                                                                                                                                                          |                     | 10B. KIND OF BUSINESS OR INDUSTRY:                                    |                 | 11. BIRTHPLACE (State or foreign country):     |            |
| <u>Draftsman</u>                                                                                                                                                                                                                               |                   |                                                                                                                                                          |                     | <u>Bethlehem Steel</u>                                                |                 | <u>Md.</u>                                     |            |
| 13. FATHER'S NAME:                                                                                                                                                                                                                             |                   |                                                                                                                                                          |                     | 14. MOTHER'S MAIDEN NAME:                                             |                 |                                                |            |
| <u>Edward N. Whaley</u>                                                                                                                                                                                                                        |                   |                                                                                                                                                          |                     | <u>Lillian M. Wilson</u>                                              |                 |                                                |            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                          |                   |                                                                                                                                                          |                     | 16. SOCIAL SECURITY NO.                                               |                 | 17. INFORMANT & ADDRESS:                       |            |
| <u>no</u>                                                                                                                                                                                                                                      |                   |                                                                                                                                                          |                     |                                                                       |                 | <u>Mrs. Pearl D. Whaley - 1718 Redwood Ave</u> |            |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                      |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                             |                   |                                                                                                                                                          |                     |                                                                       |                 | INTERVAL BETWEEN ONSET AND DEATH               |            |
| IMMEDIATE CAUSE                                                                                                                                                                                                                                |                   |                                                                                                                                                          |                     |                                                                       |                 | <u>Instant</u>                                 |            |
| (A) <u>Massive Cerebral Hemorrhage</u>                                                                                                                                                                                                         |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| ANTECEDENT CAUSE (S):                                                                                                                                                                                                                          |                   |                                                                                                                                                          |                     |                                                                       |                 | <u>1949</u>                                    |            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                                                                                                                                  |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| (B) <u>Slight Cerebral Hemorrhage</u>                                                                                                                                                                                                          |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| (C) <u>Generalized Arteriosclerosis</u>                                                                                                                                                                                                        |                   |                                                                                                                                                          |                     |                                                                       |                 | <u>?</u>                                       |            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                           |                   |                                                                                                                                                          |                     |                                                                       |                 | <u>?</u>                                       |            |
| <u>Hypertension</u>                                                                                                                                                                                                                            |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| 19A. DATE OF OPERATION:                                                                                                                                                                                                                        |                   | 19B. MAJOR FINDINGS OF OPERATION                                                                                                                         |                     |                                                                       |                 |                                                |            |
|                                                                                                                                                                                                                                                |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                             |                   | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.                                                                                     |                     | 21C. WHERE DID (City or town) INJURY OCCUR?                           |                 | (County) (State)                               |            |
|                                                                                                                                                                                                                                                |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                |                   | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                     | 21F. HOW DID INJURY OCCUR?                                            |                 |                                                |            |
|                                                                                                                                                                                                                                                |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| 22. I hereby certify that I attended the deceased from <u>6-25-1954</u> to <u>2-10-1956</u> that I last saw the deceased alive on <u>2-10-1956</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. |                   |                                                                                                                                                          |                     |                                                                       |                 |                                                |            |
| SIGNATURE                                                                                                                                                                                                                                      |                   | ADDRESS                                                                                                                                                  |                     | DATE SIGNED                                                           |                 |                                                |            |
| <u>Robert H. Hiver</u>                                                                                                                                                                                                                         |                   | <u>3105 N. Charles St.</u>                                                                                                                               |                     | <u>2-11-56</u>                                                        |                 |                                                |            |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)                                                                                                                                                                                                       |                   | DATE THEREOF                                                                                                                                             |                     | NAME OF CEMETERY OR CREMATORY                                         |                 | LOCATION (City, town, or county) (State)       |            |
| <u>Burial</u>                                                                                                                                                                                                                                  |                   | <u>2/13/56</u>                                                                                                                                           |                     | <u>David Ridge Cem.</u>                                               |                 | <u>Pikesville, Md.</u>                         |            |
| DATE REC'D BY LOCAL REGISTRAR                                                                                                                                                                                                                  |                   | REGISTRAR'S SIGNATURE                                                                                                                                    |                     | 24. FUNERAL DIRECTOR                                                  |                 | ADDRESS                                        |            |
| <u>February 11, 1956</u>                                                                                                                                                                                                                       |                   | <u>RW</u>                                                                                                                                                |                     | <u>Thos. J. Dickerson &amp; Sons</u>                                  |                 | <u>Baltimore, Md.</u>                          |            |



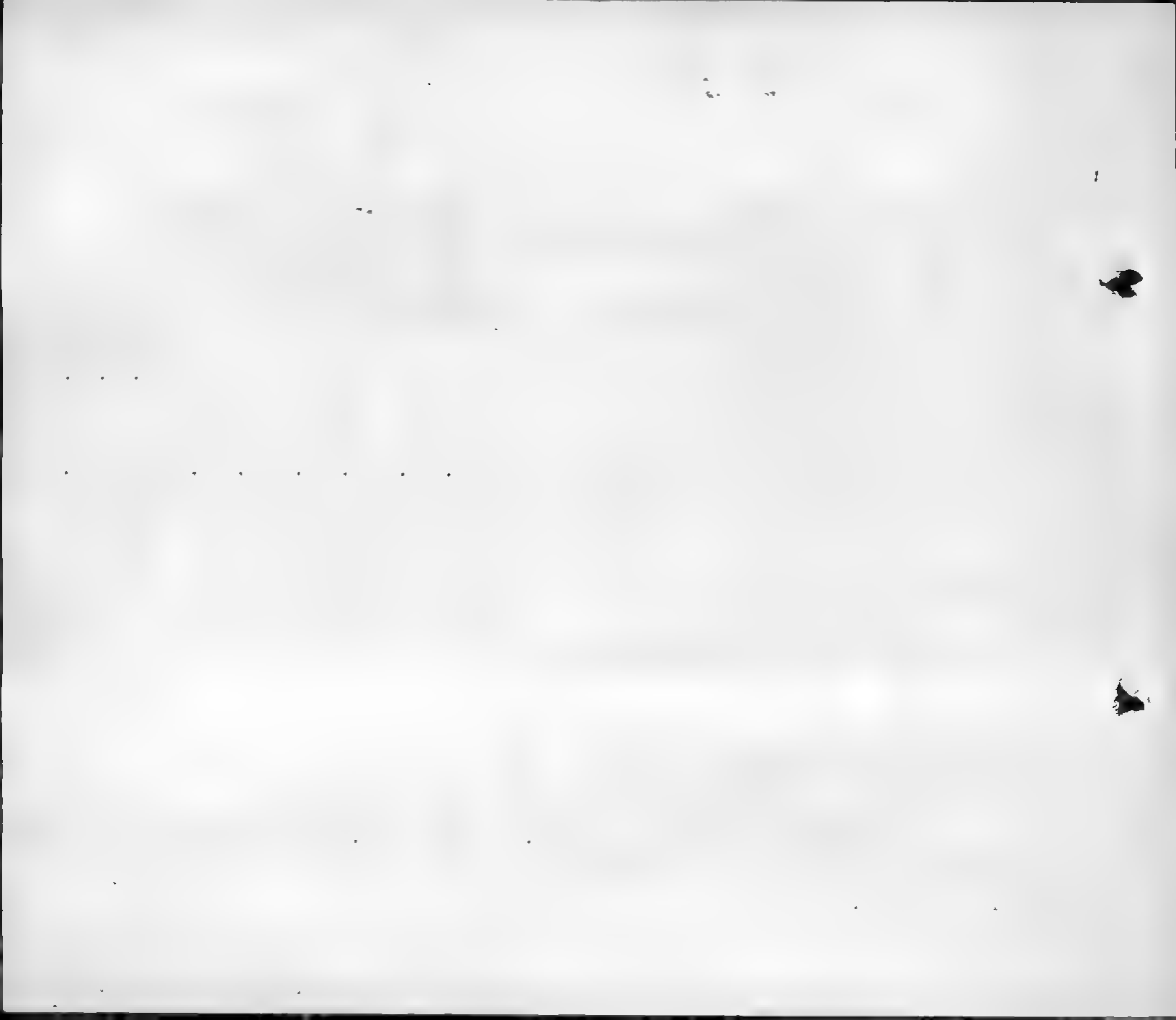
## 1575 CERTIFICATE OF DEATH

Reg. Dist. No. 4

|                                                                                                                                                                                                  |  |                                                                                                                                                          |  |                                                                                                |  |                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|----------------------------------------------|--|
| 1 PLACE OF DEATH:                                                                                                                                                                                |  |                                                                                                                                                          |  | 2 USUAL RESIDENCE (HOME) OF DECEASED:                                                          |  |                                              |  |
| COUNTY <u>BALTIMORE</u>                                                                                                                                                                          |  | MARYLAND                                                                                                                                                 |  | STATE <u>MARYLAND</u>                                                                          |  | COUNTY _____                                 |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN FORT HOWARD</u>                                                                                                 |  | LENGTH OF STAY (in this place)<br><u>12 Days</u>                                                                                                         |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWN BALTIMORE</u> |  |                                              |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>                                                                                                                |  |                                                                                                                                                          |  | STREET ADDRESS (If rural give location)<br><u>27 SOUTH PULASKI STREET</u>                      |  |                                              |  |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><u>CHARLES R. WHITE</u>                                                                                                                          |  |                                                                                                                                                          |  | 4. DATE (Month) (Day) (Year)<br>OF DEATH <u>FEBRUARY 19 19 56</u>                              |  |                                              |  |
| 5. SEX: <u>Male</u>                                                                                                                                                                              |  | 6. COLOR OR RACE: <u>White</u>                                                                                                                           |  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>                                |  | 8. DATE OF BIRTH <u>June 14, 1899</u>        |  |
| 9. AGE last birthday <u>56</u> yrs                                                                                                                                                               |  | 10. MONTHS <u>1</u> DAYS <u>1</u> HOURS <u>1</u> MIN.                                                                                                    |  | 11. BIRTHPLACE (State or foreign country): <u>Frederick, Maryland</u>                          |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Installer Heating Equipment</u>                                                                   |  |                                                                                                                                                          |  | 11. BIRTHPLACE (State or foreign country): <u>Frederick, Maryland</u>                          |  |                                              |  |
| 13. FATHER'S NAME: <u>James White</u>                                                                                                                                                            |  |                                                                                                                                                          |  | 14. MOTHER'S MAIDEN NAME: <u>Margaret Brady</u>                                                |  |                                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>                                                                    |  |                                                                                                                                                          |  | 16. SOCIAL SECURITY NO. <u>216-05-2343</u>                                                     |  |                                              |  |
| 17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>                                                                                                                     |  |                                                                                                                                                          |  | 18. MEDICAL CERTIFICATION                                                                      |  |                                              |  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                               |  |                                                                                                                                                          |  | INTERVAL BETWEEN ONSET AND DEATH                                                               |  |                                              |  |
| IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE</u>                                                                                                                              |  |                                                                                                                                                          |  | UNKNOWN                                                                                        |  |                                              |  |
| ANTECEDENT CAUSE (B) _____                                                                                                                                                                       |  |                                                                                                                                                          |  | _____                                                                                          |  |                                              |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>002X</u>                                                                                         |  |                                                                                                                                                          |  | _____                                                                                          |  |                                              |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BILATERAL FAR ADVANCED PULMONARY TUBERCULOSIS</u>                        |  |                                                                                                                                                          |  | UNKNOWN                                                                                        |  |                                              |  |
| 19A. DATE OF OPERATION: <u>2</u>                                                                                                                                                                 |  |                                                                                                                                                          |  | 19B. MAJOR FINDINGS OF OPERATION                                                               |  |                                              |  |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                 |  |                                                                                                                                                          |  | _____                                                                                          |  |                                              |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                               |  | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                                                                   |  | 21C. WHERE DID (City or town) (County) (State)                                                 |  | 21F. HOW DID INJURY OCCUR?                   |  |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>                                                                                                                              |  | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | _____                                                                                          |  |                                              |  |
| 22. I hereby certify that I attended the deceased from <u>Feb. 7, 1956</u> , to <u>Feb. 19, 1956</u> and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above. |  |                                                                                                                                                          |  |                                                                                                |  |                                              |  |
| SIGNATURE <u>D. Mark</u>                                                                                                                                                                         |  |                                                                                                                                                          |  | ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND 2-20-56</u>                                         |  |                                              |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>                                                                                                                                           |  |                                                                                                                                                          |  | DATE THEREOF <u>2-23-56</u>                                                                    |  |                                              |  |
| NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>                                                                                                                                 |  |                                                                                                                                                          |  | LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>                            |  |                                              |  |
| DATE REC'D BY LOCAL REGISTRAR <u>Feb 23, 1956</u>                                                                                                                                                |  |                                                                                                                                                          |  | 24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</u>    |  |                                              |  |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

Item 9, File 6123 2-24-56

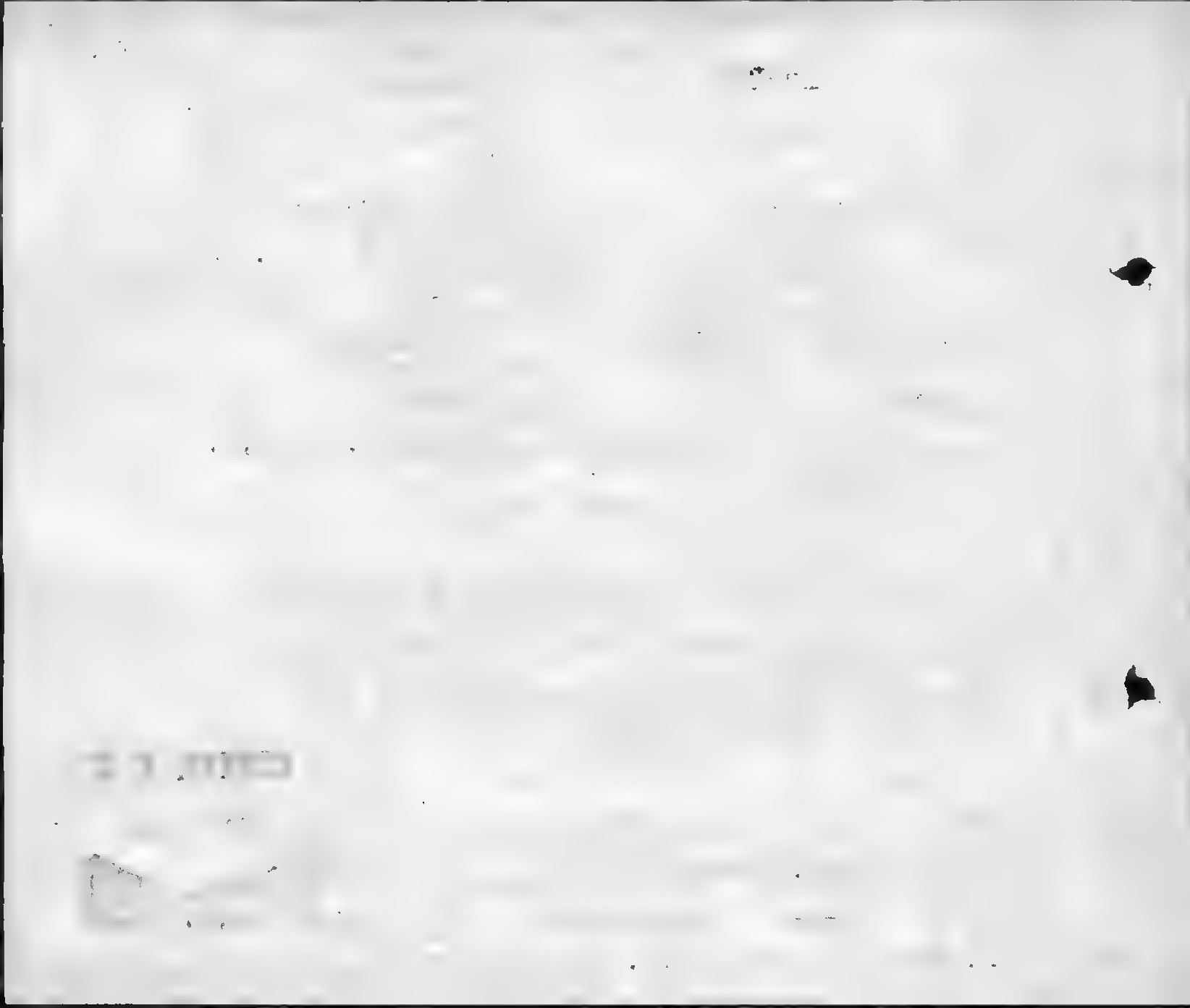
## CERTIFICATE OF DEATH

Reg. Dist. No.

01556

1576

|                                                                                                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                          |                                 |                                                                                                                                             |                                                   |                                                                                                   |                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND                                                                                                                                                                                                                                                                                              |                                  |                                                                                                                                                          |                                 | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |                                                   |                                                                                                   |                                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Daniels</b>                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                          |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Daniels</b>                                          |                                                   |                                                                                                   |                                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>107 Lower Brick Row</b>                                                                                                                                                                                                                                           |                                  |                                                                                                                                                          |                                 | d. STREET ADDRESS<br><b>107 Lower Brick Row</b>                                                                                             |                                                   |                                                                                                   |                                             |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                               |                                  |                                                                                                                                                          |                                 |                                                                                                                                             |                                                   |                                                                                                   |                                             |
| 3 NAME OF DECEASED (Type or print)<br>First <b>WALTER</b> Middle <b>PATTERSON</b> Last <b>WHITLEY</b>                                                                                                                                                                                                                                                |                                  |                                                                                                                                                          |                                 | 4 DATE OF DEATH<br>Month <b>Feb.</b> Day <b>21</b> Year <b>1956</b>                                                                         |                                                   |                                                                                                   |                                             |
| 5. SEX<br><b>Male</b>                                                                                                                                                                                                                                                                                                                                | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1874</b> |                                                                                                                                             | 9. AGE (In years last birthday)<br><b>81</b> yrs. |                                                                                                   | 10. IF UNDER 1 YEAR: Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>                                                                                                                                                                                                                                        |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cotton Mill Worker</b>                                                                                           |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>                                                                          |                                                   | 12. CITIZEN OF WHAT COUNTRY?                                                                      |                                             |
| 13. FATHER'S NAME<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                  |                                  |                                                                                                                                                          |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                                                                  |                                                   |                                                                                                   |                                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                                                               |                                  | 16. SOCIAL SECURITY NO<br><b>217-26-6696</b>                                                                                                             |                                 | 17. INFORMANT<br><b>James Shifflett Rt. 2 Elkton, Va.</b>                                                                                   |                                                   |                                                                                                   |                                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>—</b><br>(c) <b>Arteriosclerotic Cardio-Vascular Disease</b> |                                  |                                                                                                                                                          |                                 |                                                                                                                                             |                                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>                                              |                                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>                                                                                                                                                                                                        |                                  |                                                                                                                                                          |                                 |                                                                                                                                             |                                                   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)                                                                                                                                                                                                   |                                  |                                                                                                                                                          |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                                |                                                   |                                                                                                   |                                             |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                          |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                   |                                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |                                             |
| 20f. (City or town) (County) (State)                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                          |                                 |                                                                                                                                             |                                                   |                                                                                                   |                                             |
| 21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>54</b> , to <b>Feb. 21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Feb. 21</b> , 19 <b>56</b> , and that death occurred at <b>5 P.</b> M. from the causes and on the date stated above.                                                                      |                                  |                                                                                                                                                          |                                 |                                                                                                                                             |                                                   |                                                                                                   |                                             |
| ACTUAL SIGNATURE <b>William F. Cassaway</b> M.D.                                                                                                                                                                                                                                                                                                     |                                  |                                                                                                                                                          |                                 | ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b> DATE SIGNED <b>2/21/56</b>                                                  |                                                   |                                                                                                   |                                             |
| PHYSICIAN'S NAME (Type) <b>William F. Cassaway</b>                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                          |                                 | <b>Ellicott City, Md.</b>                                                                                                                   |                                                   |                                                                                                   |                                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                                                           |                                  | 22b. DATE THEREOF<br><b>2-24-56</b>                                                                                                                      |                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>                                                                                  |                                                   | 22d. LOCATION (City, town, or county) (State)<br><b>Ellicott City, Md.</b>                        |                                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>F.C. Higinbotham, Ellicott City, Md.</b>                                                                                                                                                                                                                                                                      |                                  |                                                                                                                                                          |                                 | 24. REGISTER'S SIGNATURE<br><b>Dr. Wm. Martin</b>                                                                                           |                                                   |                                                                                                   |                                             |



PLEASE TYPE OR WRITE PLAINLY, WITH UNFAILING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01557

Item 2, File # 102-2-11-56

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

|                                                                                                                                                                                                                                                                                |                                          |                                                                                                                                                          |                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                                                             |                                          | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                   |                                       |
| COUNTY <u>Balto.</u>                                                                                                                                                                                                                                                           | MARYLAND                                 | STATE <u>Md.</u>                                                                                                                                         | COUNTY <u>Baltimore</u>               |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Catonsville</u>                                                                                                                                                                            | LENGTH OF STAY (in this place)           | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>Catonsville</u>                                                      | <u>Baltimore</u>                      |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>                                                                                                                                                                                                         |                                          | STREET ADDRESS (If rural give location)<br><u>3900 Edmondson Avenue</u><br><u>Paradise, Catonsville, Md.</u>                                             |                                       |
| 3. NAME OF DECEASED: (First) (Middle) (Last)                                                                                                                                                                                                                                   | 4. DATE OF DEATH: (Month) (Day) (Year)   |                                                                                                                                                          |                                       |
| DECEASED: <u>IDA GERTRUDE WILEY</u>                                                                                                                                                                                                                                            | DEATH: <u>Feb.</u> <u>8</u> <u>19 56</u> |                                                                                                                                                          |                                       |
| 5. SEX: <u>Female</u>                                                                                                                                                                                                                                                          | 6. COLOR OR RACE: <u>white</u>           | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>                                                                                         | 8. DATE OF BIRTH: <u>Dec. 2, 1882</u> |
| 9. AGE last birthday: <u>73</u> yrs.                                                                                                                                                                                                                                           |                                          | 10. IF UNDER 1 YEAR: Months Days Hours Min.                                                                                                              |                                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>                                                                                                                                                                  |                                          | 10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>                                                                                                        |                                       |
| 11. BIRTHPLACE (State or foreign country): <u>Va.</u>                                                                                                                                                                                                                          |                                          | 12. CITIZEN OF WHAT COUNTRY?                                                                                                                             |                                       |
| 13. FATHER'S NAME: <u>John R. Carroll</u>                                                                                                                                                                                                                                      |                                          | 14. MOTHER'S MAIDEN NAME: <u>Amanda Schull</u>                                                                                                           |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give way or dates of service) <u>no</u>                                                                                                                                                       |                                          | 16. SOCIAL SECURITY NO. <u>none</u>                                                                                                                      |                                       |
| 17. INFORMANT & ADDRESS: <u>Mr. Roger C. Wiley - Balto., Md.</u>                                                                                                                                                                                                               |                                          |                                                                                                                                                          |                                       |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                      |                                          |                                                                                                                                                          |                                       |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                             |                                          |                                                                                                                                                          | INTERVAL BETWEEN ONSET AND DEATH      |
| IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>                                                                                                                                                                                                                          |                                          |                                                                                                                                                          | <u>15 minutes</u>                     |
| ANTECEDENT CAUSE (B) DUE TO                                                                                                                                                                                                                                                    |                                          |                                                                                                                                                          |                                       |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis, cerebral</u>                                                                                                                                            |                                          |                                                                                                                                                          | <u>Unknown</u>                        |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                           |                                          |                                                                                                                                                          |                                       |
| 19A. DATE OF OPERATION:                                                                                                                                                                                                                                                        |                                          | 19B. MAJOR FINDINGS OF OPERATION                                                                                                                         |                                       |
|                                                                                                                                                                                                                                                                                |                                          |                                                                                                                                                          |                                       |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)                                                                                                                             |                                          | 21B. PLACE (Home, farm, factory, street, office bldg., etc.)                                                                                             |                                       |
|                                                                                                                                                                                                                                                                                |                                          | 21C. WHERE DID (City or town) (County) (State)                                                                                                           |                                       |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                                |                                          | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                       |
|                                                                                                                                                                                                                                                                                |                                          | 21F. HOW DID INJURY OCCUR?                                                                                                                               |                                       |
| 22. I hereby certify that I attended the deceased from <u>12-16</u> , 19 <u>55</u> , to <u>2-8</u> , 19 <u>56</u> that I last saw the deceased alive on <u>2-7</u> , 19 <u>56</u> , and that death occurred at <u>3:15</u> A.M., from the causes and on the date stated above. |                                          |                                                                                                                                                          |                                       |
| SIGNATURE <u>Stephen J. Magness</u>                                                                                                                                                                                                                                            |                                          | DATE SIGNED <u>2-8-56</u>                                                                                                                                |                                       |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>                                                                                                                                                                                                                        |                                          | DATE THEREOF <u>2/10/56</u>                                                                                                                              |                                       |
| NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Pk.</u>                                                                                                                                                                                                                         |                                          | LOCATION (City, town, or county) (State) <u>Balto., Md.</u>                                                                                              |                                       |
| DATE REC'D BY LOCAL REGISTRAR <u>Feb 8, 1956</u>                                                                                                                                                                                                                               |                                          | REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>                                                                                                               |                                       |
| FUNERAL DIRECTOR <u>Wm. J. Tucker &amp; Sons</u>                                                                                                                                                                                                                               |                                          | ADDRESS <u>Balto., Md.</u>                                                                                                                               |                                       |





## CERTIFICATE OF DEATH

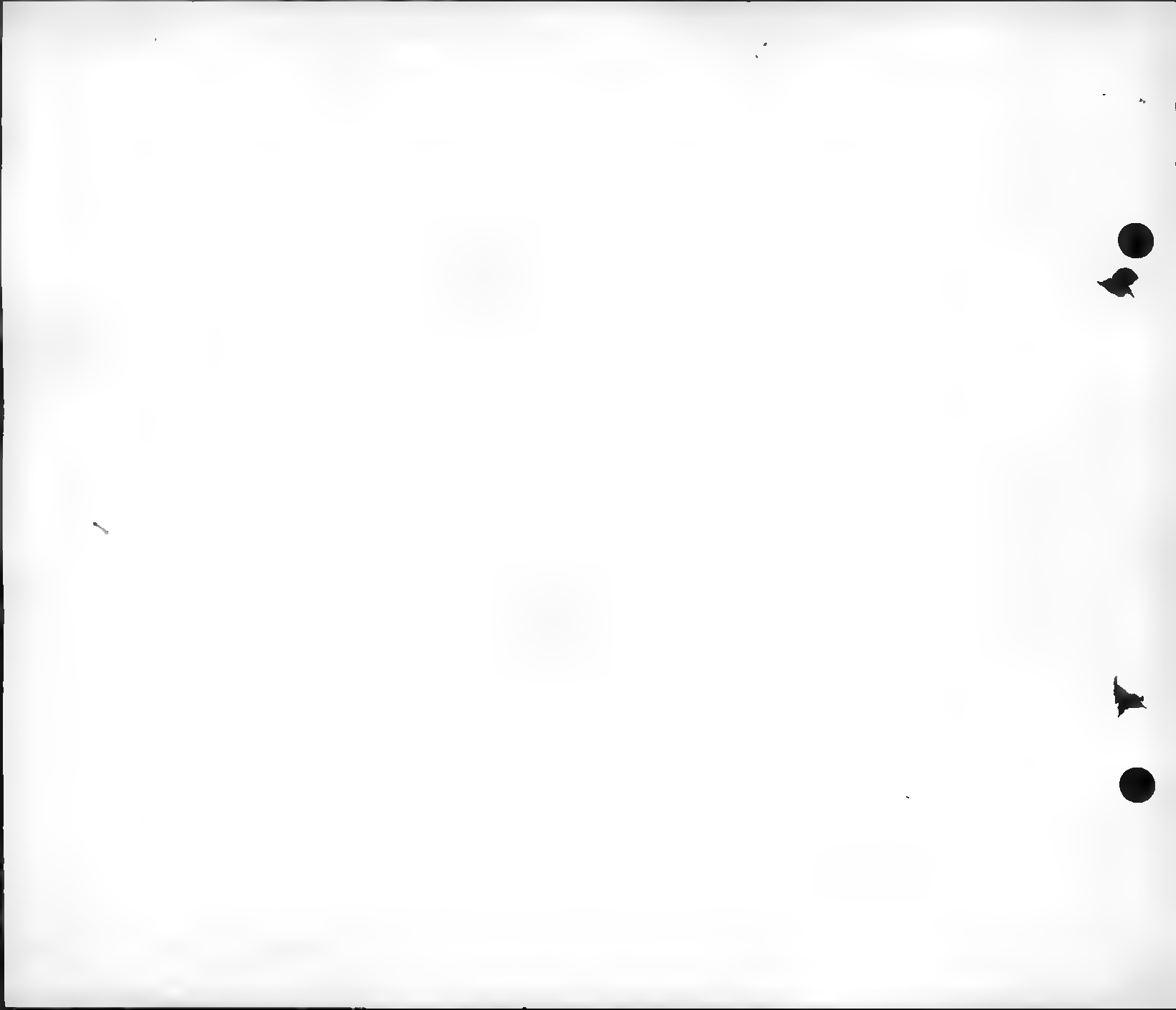
Reg. Dist. No. 30

1578

|                                                                                                                                                                                                                                                                          |                                                                                                              |                                                                                              |                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                                                       |                                                                                                              | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                       |                                                                       |
| COUNTY <u>Baltimore</u>                                                                                                                                                                                                                                                  | MARYLAND                                                                                                     | STATE <u>MD</u>                                                                              | COUNTY                                                                |
| CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) <u>Catonsville</u>                                                                                                                                                               | (in this place)                                                                                              | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk</u> |                                                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u>                                                                                                                                                                                                          |                                                                                                              | STREET ADDRESS (If rural give location) <u>2830 Southbrook Rd</u>                            |                                                                       |
| 3. NAME OF DECEASED: (First) (Middle) (Last)                                                                                                                                                                                                                             | 4. DATE OF DEATH: (Month) (Day) (Year)                                                                       |                                                                                              |                                                                       |
| <u>Bernard W. Wilson</u>                                                                                                                                                                                                                                                 | <u>Feb 28</u> 19 <u>56</u>                                                                                   |                                                                                              |                                                                       |
| 5. SEX: <u>M</u>                                                                                                                                                                                                                                                         | 6. COLOR OR RACE: <u>W</u>                                                                                   | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>                               | 8. DATE OF BIRTH: <u>Feb 22 1898</u>                                  |
|                                                                                                                                                                                                                                                                          |                                                                                                              | 9. AGE last birthday: <u>78</u> yrs.                                                         | 10. BIRTHPLACE (State or foreign country): <u>MD</u>                  |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired. <u>Paper Hanger</u>                                                                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY:                                                                           | 11. BIRTHPLACE (State or foreign country):                                                   | 12. CITIZEN OF WHAT COUNTRY?                                          |
| 13. FATHER'S NAME: <u>Carl Wilson</u>                                                                                                                                                                                                                                    | 14. MOTHER'S MAIDEN NAME: <u>Louise Rowston</u>                                                              |                                                                                              |                                                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                    | 16. SOCIAL SECURITY No.:                                                                                     | 17. INFORMANT & ADDRESS: <u>W. Wilson 2830 Southbrook</u>                                    |                                                                       |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                |                                                                                                              |                                                                                              |                                                                       |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                      |                                                                                                              |                                                                                              | Interval Between Onset And Death                                      |
| Immediate cause (a) <u>Coronary Heart Failure</u>                                                                                                                                                                                                                        |                                                                                                              |                                                                                              | <u>2 days</u>                                                         |
| Antecedent causes (b) <u>Arteriosclerotic Heart Disease</u>                                                                                                                                                                                                              |                                                                                                              |                                                                                              |                                                                       |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Examination of Prostate</u>                                                                                                                                     |                                                                                                              |                                                                                              |                                                                       |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                                      |                                                                                                              |                                                                                              |                                                                       |
| 19a. DATE OF OPERATION:                                                                                                                                                                                                                                                  | 19b. MAJOR FINDINGS OF OPERATION                                                                             |                                                                                              | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify)                                                                                                                                                                                                                                  | PLACE (Home, farm, factory, street, or office bldg., etc.)                                                   | (CITY OR TOWN)                                                                               | (COUNTY) (STATE)                                                      |
| TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                                               | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR?                                                                        |                                                                       |
| 22. I hereby certify that I attended the deceased from <u>Dec 1956</u> , to <u>death</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 26, 1956</u> , and that death occurred at <u>7526 Halsted Ave</u> , from the causes and on the date stated above. |                                                                                                              |                                                                                              |                                                                       |
| SIGNATURE <u>Guillermo Benito MD</u>                                                                                                                                                                                                                                     |                                                                                                              | DATE SIGNED <u>2/1/56</u>                                                                    |                                                                       |
| 23. BURIAL, CREMATION, REMOVAL (Specify)                                                                                                                                                                                                                                 | DATE THEREOF                                                                                                 | NAME OF CEMETERY OR CREMATORY                                                                | LOCATION (City, town or county) (State)                               |
| <u>Burial</u>                                                                                                                                                                                                                                                            | <u>Mar 3/56</u>                                                                                              | <u>Bethel Am</u>                                                                             | <u>Catonsville MD</u>                                                 |
| DATE REC'D BY LOCAL REGISTRAR                                                                                                                                                                                                                                            | REGISTRAR'S SIGNATURE <u>[Signature]</u>                                                                     | 24. FUNERAL DIRECTOR <u>Wilbur Ford Home 2112 Dundalk Ave</u>                                |                                                                       |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 2111

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                 |                                                                                                                                                                                                     |                                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                                                              |                                                            |
| COUNTY <b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          | MARYLAND                                        | STATE <b>Penna.</b>                                                                                                                                                                                 | COUNTY                                                     |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br>TOWN <b>Reisterstown, Md.</b>                                                                                                                                                                                                                                                                                                                                                        | LENGTH OF STAY (In this place)<br><b>1 Week</b> | CITY (If outside corporate limits write RURAL and give nearest town)<br>OR TOWN <b>Philadelphia</b>                                                                                                 |                                                            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Bond Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                 | STREET ADDRESS (If rural, give location)<br><b>4530 Pine Street</b>                                                                                                                                 |                                                            |
| 3. NAME OF DECEASED: (First) <b>Hannah</b> (Middle) <b>B.</b> (Last) <b>Wilson</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                 | 4. DATE OF DEATH (Month) <b>Feb.</b> (Day) <b>20</b> (Year) <b>19 56</b>                                                                                                                            |                                                            |
| 6. SEX: <b>F.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. COLOR OR RACE: <b>W.</b>                     | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>SINGLE</b>                                                                                                                                     | 8. DATE OF BIRTH: <b>April 3, 1886</b>                     |
| 9. AGE last birthday: <b>69</b> yrs.                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                 | IF UNDER 1 YEAR Months Days                                                                                                                                                                         | IF UNDER 24 HRS. Hours Min.                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Retired Teacher</b>                                                                                                                                                                                                                                                                                                                                                 |                                                 | 10b. KIND OF BUSINESS OR INDUSTRY:                                                                                                                                                                  | 11. BIRTHPLACE (State or foreign country): <b>Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 | 13. FATHER'S NAME: <b>John E. Wilson</b>                                                                                                                                                            |                                                            |
| 14. MOTHER'S MAIDEN NAME: <b>Hannah B. Broomall</b>                                                                                                                                                                                                                                                                                                                                                                                                              |                                                 | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If yes, give war or dates of service) <b>no</b>                                                                           |                                                            |
| 16. SOCIAL SECURITY No.:                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                 | 17. INFORMANT & ADDRESS: <b>Fred Wilson Reisterstown, Md.</b>                                                                                                                                       |                                                            |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                 |                                                                                                                                                                                                     |                                                            |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                                                                                                                                                                                                                                                                                                                                             |                                                 |                                                                                                                                                                                                     | INTERVAL BETWEEN ONSET AND DEATH                           |
| Immediate cause (a) <b>Coronary Occlusion</b><br>DUE TO                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 |                                                                                                                                                                                                     | <b>30 min.</b>                                             |
| Antecedent cause(s) (b) <b>Arteriosclerotic C-V. Disease</b><br>Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)                                                                                                                                                                                                                                                                                          |                                                 |                                                                                                                                                                                                     | <b>3 mos.</b>                                              |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>                                                                                                                                                                                                                                                                                                                                |                                                 |                                                                                                                                                                                                     |                                                            |
| 19a. DATE OF OPERATION: <b>none</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                 | 19b. MAJOR FINDING OF OPERATION: <b>none</b>                                                                                                                                                        |                                                            |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                 |                                                 |                                                                                                                                                                                                     |                                                            |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>none</b>                                                                                                                                                                                                                                                                                                                         |                                                 | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>none</b>                                                                                                                  |                                                            |
| 21c. (City or town) <b>none</b> (County) <b>none</b> (State) <b>none</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                 |                                                                                                                                                                                                     |                                                            |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                 | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                                                                   |                                                            |
| 21f. HOW DID INJURY OCCUR? <b>none</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |                                                                                                                                                                                                     |                                                            |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> |                                                 |                                                                                                                                                                                                     |                                                            |
| SIGNATURE <b>D. L. Eplee</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2-21-56</b><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |                                                            |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 | DATE THEREOF <b>Feb. 22, 56</b>                                                                                                                                                                     |                                                            |
| NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                 | LOCATION (City, town, or county) (State) <b>Elkton Md.</b>                                                                                                                                          |                                                            |
| DATE REC'D BY LOCAL REG. <b>2-21-56</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 | REGISTRAR'S SIGNATURE <b>[Signature]</b>                                                                                                                                                            |                                                            |
| 24. FUNERAL DIRECTOR <b>J.F. Eline &amp; Son's Reisterstown, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                 | ADDRESS                                                                                                                                                                                             |                                                            |

WILSON, W. B.

FEB

1950

1580

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01560

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 9. Film G193 2-27-56 et

|                                                                                                                       |                                  |                                                                                           |                                                               |
|-----------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <b>Baltimore</b>                                                                          |                                  | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <b>Maryland</b> COUNTY                     |                                                               |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>                           |                                  | CITY (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |                                                               |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>Paradise Nursing Home</b>                                             |                                  | STREET ADDRESS<br><b>706 E. Arlington Ave.</b>                                            |                                                               |
| 3. NAME OF DECEASED<br>(Type or Print)                                                                                | (First) <b>Mary</b>              | (Middle) <b>Agnes</b>                                                                     | (Last) <b>Woods</b>                                           |
| 6. SEX<br><b>Female</b>                                                                                               | 6. COLOR OR RACE<br><b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>                            | 8. DATE OF BIRTH<br><b>Unknown Approx. 82 ? yrs.</b>          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housekeeper</b>     |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Church Rectory</b>                                | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore</b> |
| 13. FATHER'S NAME<br><b>? ? Woods</b>                                                                                 |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>                                                |                                                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b> |                                  | 16. SOCIAL SECURITY No.<br><b>unknown</b>                                                 |                                                               |
| 17. INFORMANT AND ADDRESS<br><b>James P. Walsh 806 Md. Trust Bldg.</b>                                                |                                  | 18. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                              |                                                               |

## 18. MEDICAL CERTIFICATION

|                                                                                                                                                         |                                                                                                   |                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                     |                                                                                                   | INTERVAL BETWEEN ONSET AND DEATH                                                 |
| Immediate cause (a) <b>Myocardial failure</b>                                                                                                           |                                                                                                   | <b>72 hrs</b>                                                                    |
| Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Atherosclerotic CVD</b> |                                                                                                   | <b>Unknown</b>                                                                   |
| 11. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                     |                                                                                                   |                                                                                  |
| 19a. DATE OF OPERATION                                                                                                                                  | 19b. MAJOR FINDINGS OF OPERATION                                                                  | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE                                                                                                           | PLACE (Home, farm, factory, street, office bldg., etc.)<br>INJURY                                 | (CITY OR TOWN) (COUNTY) (STATE)                                                  |
| TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                              | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR?                                                            |

22. I hereby certify that I attended the deceased from 12-8, 1959, to 2-20, 1956, that I last saw the deceased alive on 2-19, 1956, and that death occurred at 1:00 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

|                                                          |                                               |                                                            |                                                          |
|----------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------|----------------------------------------------------------|
| 23. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b> | DATE THEREOF<br><b>2/23/56</b>                | NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b> | LOCATION (City, town, or county)<br><b>Baltimore Md.</b> |
| DATE REC'D BY LOCAL REG.<br><b>Feb 27 1956</b>           | REGISTRAR'S SIGNATURE<br><b>G. W. Hedrick</b> | 24. FUNERAL DIRECTOR<br><b>John A. Moran</b>               | ADDRESS<br><b>3000 E. Baltimore St</b>                   |

T-1 Per H. E. Lewis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01561

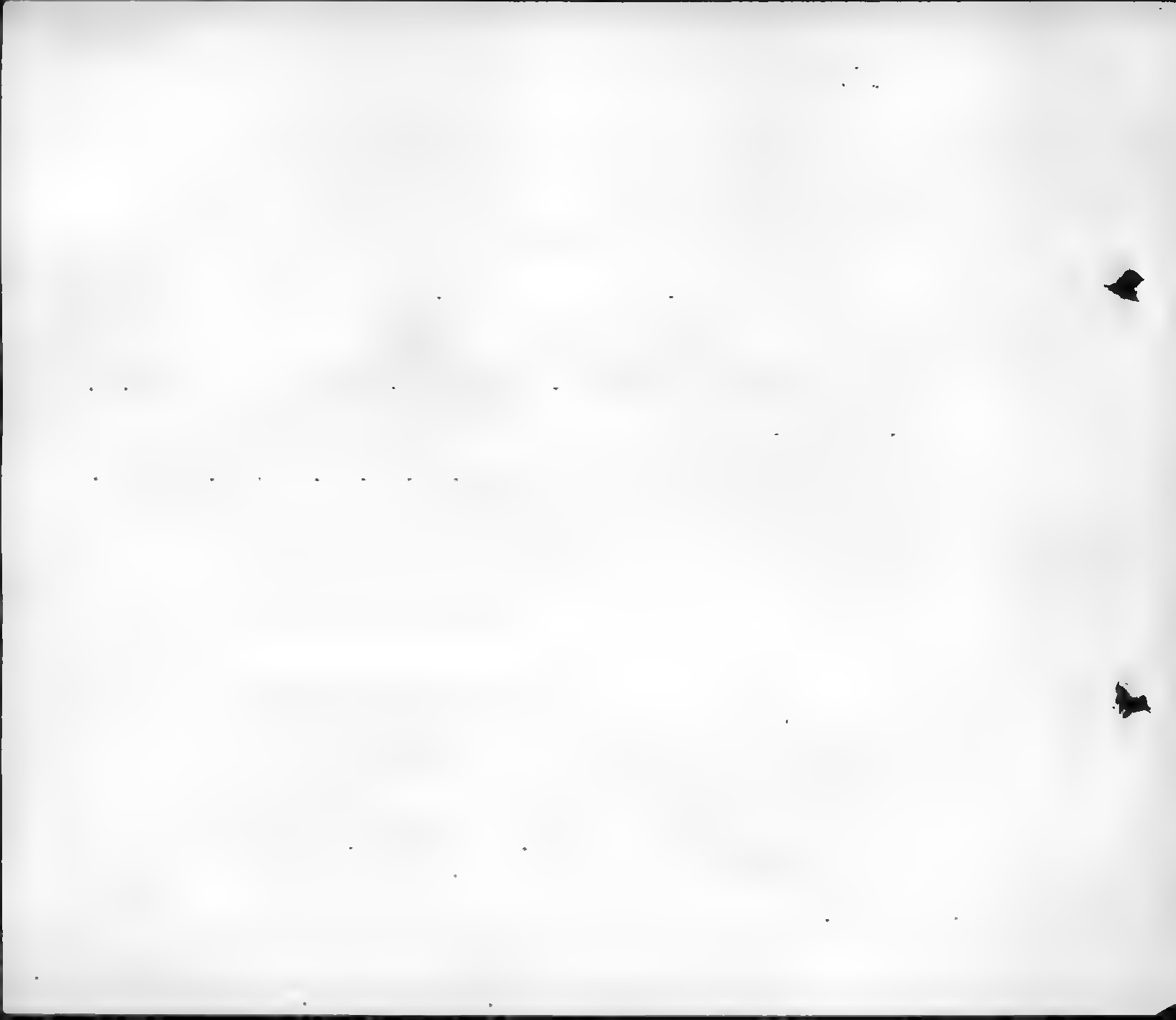
Items 8,9 File 0192 2-11-56 et

1581

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                                                                                                                                                                |                                                 |                                                                                                |                                            |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                             |                                                 | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                         |                                            |
| COUNTY <b>Baltimore</b>                                                                                                                                                                        | MARYLAND                                        | STATE <b>Maryland</b>                                                                          | COUNTY                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Fort Howard</b>                                                                                               | LENGTH OF STAY (in this place)<br><b>5 Days</b> | CITY: If outside corporate limits, write RURAL and give nearest town)<br>TOWN <b>Baltimore</b> |                                            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>                                                                                                              |                                                 | STREET ADDRESS (If rural give location)<br><b>222 South Vincent Street</b>                     |                                            |
| 3. NAME OF DECEASED: (First) (Middle) (Last)<br><b>SHERMAN L. WOOD, JR.</b>                                                                                                                    |                                                 | 4. DATE (Month) (Day) (Year)<br>OF DEATH: <b>February 1 1956</b>                               |                                            |
| 5. SEX: <b>Male</b>                                                                                                                                                                            | 6. COLOR OR RACE: <b>White</b>                  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>                                | 8. DATE OF BIRTH: <b>July 8, 1918 1919</b> |
| 9. AGE last birthday: <b>37</b> yrs.                                                                                                                                                           |                                                 | 10. MONTHS: <b>36</b>                                                                          | 11. DAYS: <b>36</b>                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Tool &amp; Die Maker Tool &amp; Die Co.</b>                                                    |                                                 | 10B. KIND OF BUSINESS OR INDUSTRY: <b>Tool &amp; Die Co.</b>                                   |                                            |
| 11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b>                                                                                                                          |                                                 | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                                                   |                                            |
| 13. FATHER'S NAME: <b>Sherman L. Wood, Sr.</b>                                                                                                                                                 |                                                 | 14. MOTHER'S MAIDEN NAME: <b>Emma Deming</b>                                                   |                                            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>Yes WW II</b>                                                                         |                                                 | 16. SOCIAL SECURITY NO. <b>219-07-4592</b>                                                     |                                            |
| 17. INFORMANT & ADDRESS: <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>                                                                                                                    |                                                 |                                                                                                |                                            |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                      |                                                 |                                                                                                | INTERVAL BETWEEN ONSET AND DEATH           |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                             |                                                 |                                                                                                |                                            |
| IMMEDIATE CAUSE (A) <b>VIRAL ENCEPHALITIS</b>                                                                                                                                                  |                                                 |                                                                                                | <b>10 DAYS</b>                             |
| ANTECEDENT CAUSE (B) DUE TO                                                                                                                                                                    |                                                 |                                                                                                |                                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO                                                                                       |                                                 |                                                                                                |                                            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                           |                                                 |                                                                                                |                                            |
| 19A. DATE OF OPERATION:                                                                                                                                                                        |                                                 | 19B. MAJOR FINDINGS OF OPERATION                                                               |                                            |
|                                                                                                                                                                                                |                                                 |                                                                                                |                                            |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                               |                                                 |                                                                                                |                                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                               |                                                 | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                         |                                            |
| 21C. WHERE DID (City or town) (County) (State)                                                                                                                                                 |                                                 | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                |                                            |
| 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                                       |                                                 | 21F. HOW DID INJURY OCCUR?                                                                     |                                            |
| 22. I hereby certify that I attended the deceased from <b>Jan. 27, 1956</b> to <b>Feb. 1, 1956</b> and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. |                                                 |                                                                                                |                                            |
| SIGNATURE <b>D. D. MARK, M.D.</b>                                                                                                                                                              |                                                 | ADDRESS <b>FORT HOWARD, MARYLAND</b>                                                           |                                            |
| DATE SIGNED <b>2/2/56</b>                                                                                                                                                                      |                                                 |                                                                                                |                                            |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                                                                                                                                         |                                                 | DATE THEREOF <b>2-6-56</b>                                                                     |                                            |
| NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>                                                                                                                                        |                                                 | LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>                            |                                            |
| DATE REC'D BY LOCAL REGISTRAR                                                                                                                                                                  |                                                 | REGISTRAR'S SIGNATURE                                                                          |                                            |
| 24. FUNERAL DIRECTOR                                                                                                                                                                           |                                                 | ADDRESS <b>Md.</b>                                                                             |                                            |
| <b>Wm. Cook-Blight, Inc., 6009 Harford Road, Balto.</b>                                                                                                                                        |                                                 |                                                                                                |                                            |





## 1582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 12, 13, 14, 15 Film G193 3-9-56 et

Reg. Dist. No.

44

|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                             |                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>Ore Mar Steamship MARYLAND                                                                                                                                                                                                                                                                                                                                                                               |                                  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>                |                                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sparrows Point Ore Dock</u>                                                                                                                                                                                                                                                                                                                                          |                                  | c. LENGTH OF STAY IN 1b<br><u>20 hrs.</u>                                                                                                                   |                                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)                                                                                                                                                                                                                                                                                                                                                                                |                                  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE</u>                                                        |                                                |
| 3. NAME OF DECEASED<br>(Type or print) <u>WORMANEN</u> First <u>Jacob</u> Middle <u></u> Last <u>Wornanen</u>                                                                                                                                                                                                                                                                                                                                               |                                  | d. STREET ADDRESS<br><u>1216 E. Baltimore St.</u>                                                                                                           |                                                |
| 4. DATE OF DEATH<br><u>2-29-56</u> Month <u>29</u> Day <u>29</u> Year <u>19</u>                                                                                                                                                                                                                                                                                                                                                                             |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                           |                                                |
| 5. SEX<br><u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-26-92</u>            |
| 9. AGE (In years last birthday)<br><u>63</u> yrs.                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u>                                                                                                              | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Seaman</u>                                                                                                                                                                                                                                                                                                                                                |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Steamship</u>                                                                                                       |                                                |
| 11. BIRTHPLACE (State or foreign country)<br><u>Unknown</u>                                                                                                                                                                                                                                                                                                                                                                                                 |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>Unknown</u>                                                                                                              |                                                |
| 13. FATHER'S NAME<br><u>Unknown</u>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                                                                                                                  |                                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>Unknown</u>                                                                                                                                                                                                                                                                                                                                                                        |                                  | 16. SOCIAL SECURITY NO<br><u>216-12-8837</u>                                                                                                                |                                                |
| 17. INFORMANT<br><u>Records of ore steamship co.</u>                                                                                                                                                                                                                                                                                                                                                                                                        |                                  | Address <u></u>                                                                                                                                             |                                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u></u><br>(c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u></u>        |                                  |                                                                                                                                                             |                                                |
| INTERVAL BETWEEN ONSET AND DEATH<br><u></u>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                             |                                                |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                             |                                                |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.<br><u>NONE</u>                                                                                                                                                                                                                                                                                                                 |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>NONE</u>                                                 |                                                |
| 20c. TIME OF INJURY<br>Hour <u></u> o. m. <u></u> p. m. <u>19</u>                                                                                                                                                                                                                                                                                                                                                                                           |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                                   |                                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>                                                                                                                                                                                                                                                                                                                                                                           |                                  | 20f. (City or town) (County) (State)<br><u></u>                                                                                                             |                                                |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |                                                                                                                                                             |                                                |
| ACTUAL SIGNATURE<br><u>M. B. Davis</u>                                                                                                                                                                                                                                                                                                                                                                                                                      |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                                                                                        |                                                |
| EXAMINER'S NAME (Type)<br><u>M. B. Davis, M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                          |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                                                                                         |                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                                                                                 |                                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 22b. DATE THEREOF<br><u>Mar. 2/56</u>                                                                                                                       |                                                |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Mem.</u>                                                                                                                                                                                                                                                                                                                                                                                                  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore</u>                                                                                           |                                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Philip Herung Sone</u>                                                                                                                                                                                                                                                                                                                                                                                               |                                  | ADDRESS<br><u>2024 Orleans</u>                                                                                                                              |                                                |
| 24a. REC'D BY REGISTRAR<br><u>MAR 2 1956</u>                                                                                                                                                                                                                                                                                                                                                                                                                |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Sawson L. Larkin</u>                                                                                                       |                                                |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S.

UNITED STATES

OFFICE

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

01563

1583

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

|                                                                                                                  |                               |                                                                                         |                                     |
|------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------|
| 1. PLACE OF DEATH<br>COUNTY <u>Baltimore Co</u> MARYLAND                                                         |                               | 2. USUAL RESIDENCE (HOME) OF DECEASED<br>STATE <u>Maryland</u> COUNTY <u>Baltimore</u>  |                                     |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>                          |                               | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> |                                     |
| TOWN <u>Pikesville</u>                                                                                           |                               | TOWN <u>Pikesville</u>                                                                  |                                     |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                                        |                               | STREET ADDRESS (If rural, give location) <u>7 Sudbrook Court</u>                        |                                     |
| 3. NAME OF DECEASED (First) <u>Margaret</u> (Middle) <u>Wurzbarger</u> (Last) <u>Wurzbarger</u>                  |                               | 4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>29</u> (Year) <u>1956</u>                  |                                     |
| 5. SEX <u>Female</u>                                                                                             | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>                           | 8. DATE OF BIRTH <u>Apr 1, 1873</u> |
| 9. AGE last birthday <u>82</u> yrs. <u>10</u> months <u>28</u> days                                              |                               | 10. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>                      |                                     |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>      |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                                 |                                     |
| 13. FATHER'S NAME <u>Clarence Dias</u>                                                                           |                               | 14. MOTHER'S MAIDEN NAME <u>Lucietia Abraham</u>                                        |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If year, give war or dates of service)</u> |                               | 16. SOCIAL SECURITY No. <u>7 Sudbrook Crt, Pikesville, Md</u>                           |                                     |
| 17. INFORMANT AND ADDRESS <u>Stanley L. Wurzbarger</u>                                                           |                               | 18. MEDICAL CERTIFICATION                                                               |                                     |

|                                                                                                                                                               |                                                                                                                       |                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                           |                                                                                                                       | INTERVAL BETWEEN ONSET AND DEATH                                      |
| Immediate cause (a) <u>BRONCHO PNEUMONIA, ACUTE</u>                                                                                                           |                                                                                                                       | <u>4 days</u>                                                         |
| Antecedent cause(s) (b) <u>CEREBRAL THROMBOSIS</u>                                                                                                            |                                                                                                                       | <u>3 months</u>                                                       |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIOSCLEROTIC HEART DISEASE &amp; HYPERTENSION</u> |                                                                                                                       | <u>5 years</u>                                                        |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |                                                                                                                       |                                                                       |
| 19a. DATE OF OPERATION                                                                                                                                        | 19b. MAJOR FINDINGS OF OPERATION                                                                                      | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) <u>SUICIDE</u>                                                                                                                         | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>                                              | (CITY OR TOWN) (COUNTY) (STATE)                                       |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>                                                                                                          | INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/> | HOW DID INJURY OCCUR?                                                 |

22. I hereby certify that I attended the deceased from Nov 18, 1955, to Feb 29, 1956, that I last saw the deceased alive on Feb 29, 1956, and that death occurred at 11:20 AM, from the causes and on the date stated above.

SIGNATURE Caroline H. Spangberg M.D. (Degree or title) ADDRESS 5329 Reisterstown Rd Baltimore, Md DATE SIGNED March 1, 1956

|                                                       |                                          |                                                           |                                                                |
|-------------------------------------------------------|------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE <u>3-2-56</u>                       | NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Cem</u> | LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) |
| DATE REC'D BY LOCAL REG. <u>Mar 2, 1956</u>           | REGISTRAR'S SIGNATURE <u>[Signature]</u> | 24. FUNERAL DIRECTOR <u>David R. Martin</u>               | ADDRESS <u>1902 Eutaw Place</u>                                |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



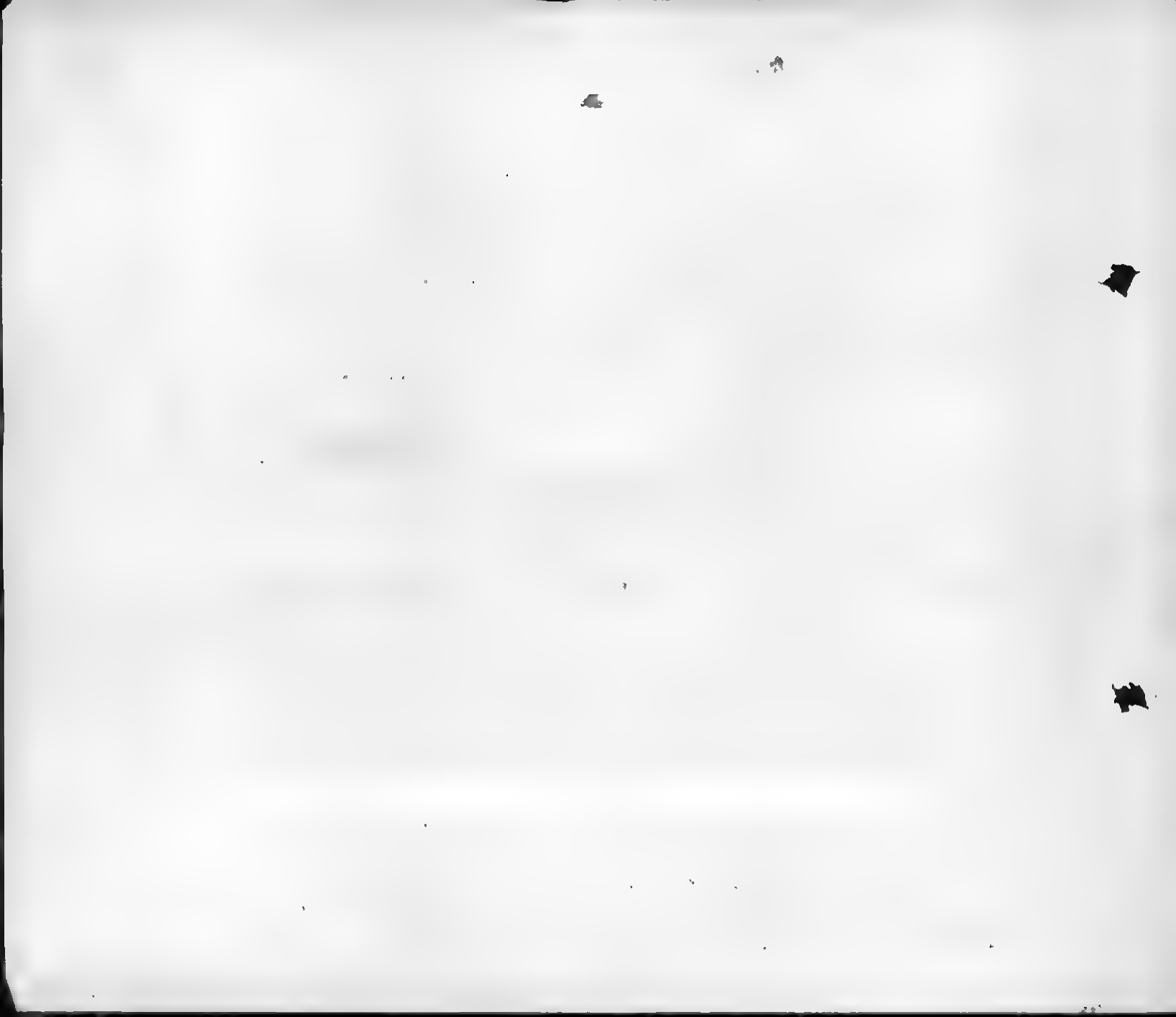
## 1584 CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

|                                                                                                                                                                                                                                                 |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------------------------------|----------------------------|
| 1. PLACE OF DEATH:                                                                                                                                                                                                                              |                                |                                                                                                        |                                        | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                         |                        |                                                                         |                            |
| COUNTY <b>Baltimore</b>                                                                                                                                                                                                                         |                                | MARYLAND                                                                                               |                                        | STATE <b>Md.</b>                                                                               |                        | COUNTY <b>Baltimore</b>                                                 |                            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)                                                                                                                                                                        |                                | LENGTH OF STAY (in this place)                                                                         |                                        | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b> |                        |                                                                         |                            |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>3801 Locheam Drive</b>                                                                                                                                                                             |                                |                                                                                                        |                                        | STREET ADDRESS (If rural give location) <b>3801 Locheam Drive</b>                              |                        |                                                                         |                            |
| 3. NAME OF DECEASED: (First) <b>John</b> (Middle) <b>Odgers</b> (Last) <b>Young, Sr.</b>                                                                                                                                                        |                                |                                                                                                        |                                        | 4. DATE (Month) (Day) (Year) OF DEATH: <b>Feb. 9 1956</b>                                      |                        |                                                                         |                            |
| 5. SEX <b>Male</b>                                                                                                                                                                                                                              | 6. COLOR OR RACE: <b>White</b> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>                                        | 8. DATE OF BIRTH: <b>Apr. 18, 1892</b> | 9. AGE last birthday <b>63</b> yrs.                                                            | IF UNDER 1 YEAR Months | IF UNDER 24 HRS Days                                                    | IF UNDER 24 HRS Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>President - Progressive Brass Die</b>                                                                                                           |                                | 10B. KIND OF BUSINESS OR INDUSTRY:                                                                     |                                        | 11. BIRTHPLACE (State or foreign country): <b>Phila., Pa.</b>                                  |                        | 12. CITIZEN OF WHAT COUNTRY?                                            |                            |
| 13. FATHER'S NAME: <b>William H. Young</b>                                                                                                                                                                                                      |                                |                                                                                                        |                                        | 14. MOTHER'S MAIDEN NAME: <b>Unknown</b>                                                       |                        |                                                                         |                            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service                                                                                                                                             |                                |                                                                                                        |                                        | 16. SOCIAL SECURITY NO.                                                                        |                        | 17. INFORMANT & ADDRESS: <b>Sarah Warner Young - 3801 Locheam Drive</b> |                            |
| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                       |                                |                                                                                                        |                                        |                                                                                                |                        | INTERVAL BETWEEN ONSET AND DEATH                                        |                            |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                              |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
| IMMEDIATE CAUSE (A) <b>Cornary Occlusion</b>                                                                                                                                                                                                    |                                |                                                                                                        |                                        |                                                                                                |                        | <b>2 hrs</b>                                                            |                            |
| ANTECEDENT CAUSE (S):                                                                                                                                                                                                                           |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>Myocardial Infarction</b>                                                                                                                  |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
| (C) <b>Cerebral &amp; Liver</b>                                                                                                                                                                                                                 |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                            |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
| 19A. DATE OF OPERATION: <b>0</b>                                                                                                                                                                                                                |                                | 19B. MAJOR FINDINGS OF OPERATION                                                                       |                                        |                                                                                                |                        |                                                                         |                            |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                              |                                | 21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)                                   |                                        | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?                                   |                        | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY                                                                                                                                                                                                 |                                | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work |                                        | 21F. HOW DID INJURY OCCUR?                                                                     |                        |                                                                         |                            |
| 22. I hereby certify that I attended the deceased from <b>Jan, 1956</b> to <b>Feb., 1956</b> that I last saw the deceased alive on <b>Feb 7, 1956</b> and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above. |                                |                                                                                                        |                                        |                                                                                                |                        |                                                                         |                            |
| SIGNATURE <b>Thos. J. R. R. R. R.</b>                                                                                                                                                                                                           |                                | M.D. <b>4509 South Heights</b>                                                                         |                                        | DATE SIGNED <b>2-11-56</b>                                                                     |                        |                                                                         |                            |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>                                                                                                                                                                                      |                                | DATE THEREOF <b>Feb. 13, 1956</b>                                                                      |                                        | NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>                                        |                        | LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>          |                            |
| DATE REC'D BY LOCAL REGISTRAR <b>2-13-56</b>                                                                                                                                                                                                    |                                | REGISTRAR'S SIGNATURE <b>Wm. H. R. R. R.</b>                                                           |                                        | 24. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>                                     |                        | ADDRESS <b>4600 Liberty Heights Ave.</b>                                |                            |

MARGIN RESERVED FOR BINDING



1585 CERTIFICATE OF DEATH

Items 9, 13, 14 Film GI 93 3-9-56 et

Reg. Dist. No. 38

|                                                                                                       |                                    |                                                                       |                              |
|-------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------|------------------------------|
| 1. PLACE OF DEATH:                                                                                    |                                    | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                |                              |
| COUNTY Baltimore                                                                                      | MARYLAND                           | STATE Md                                                              | County Proctor City          |
| CITY (If outside corporate limits, write RURAL and give nearest town)                                 | LENGTH OF STAY (in this place)     | CITY (If outside corporate limits, write RURAL and give nearest town) |                              |
| TOWN Rural: Towson                                                                                    |                                    | TOWN Baltimore City                                                   |                              |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                             |                                    | STREET ADDRESS                                                        | (If rural give location)     |
| Eudowood Sanatorium                                                                                   |                                    | 219 W. Mulberry St.                                                   |                              |
| Towson 4, Maryland                                                                                    |                                    |                                                                       |                              |
| 3. NAME OF DECEASED:                                                                                  |                                    | 4. DATE OF DEATH:                                                     |                              |
| (Type or Print)                                                                                       | First (Middle) (Last)              | (Month) (Day) (Year)                                                  |                              |
| Tom                                                                                                   | Yuem                               | 2 27 1956                                                             |                              |
| 5. SEX:                                                                                               | 6. COLOR OR RACE:                  | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):                     | 8. DATE OF BIRTH:            |
| Sm.                                                                                                   | Yellow                             |                                                                       | 9/9/1880                     |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.           | 10b. KIND OF BUSINESS OR INDUSTRY: | 9. AGE last birthday: IF UNDER 1 YEAR                                 | 12. CITIZEN OF WHAT COUNTRY? |
| Chinese helper                                                                                        | Restaurant                         | 75 yrs. Months Days Hours Min.                                        | China                        |
| 13. FATHER'S NAME:                                                                                    |                                    | 14. MOTHER'S MAIDEN NAME:                                             |                              |
| Unknown                                                                                               |                                    | Unknown                                                               |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) |                                    | 16. SOCIAL SECURITY No.:                                              |                              |
|                                                                                                       |                                    | 17. INFORMANT & ADDRESS:                                              |                              |

|                                                                                                                                                    |                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 18. MEDICAL CERTIFICATION                                                                                                                          |                                  |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                | Interval Between Onset And Death |
| 002X Immediate cause (a) Cardiac decompensation                                                                                                    | 3 mos.                           |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Pulmonary tuberculosis | (?)                              |
| (c)                                                                                                                                                |                                  |

|                                                                                                 |                                  |                                                                     |  |
|-------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------|--|
| 11. OTHER SIGNIFICANT CONDITIONS                                                                |                                  | 29. AUTOPSY ?                                                       |  |
| Conditions contributing to the death but not related to the disease or condition causing death. |                                  | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 19a. DATE OF OPERATION:                                                                         | 19b. MAJOR FINDINGS OF OPERATION |                                                                     |  |
|                                                                                                 |                                  |                                                                     |  |

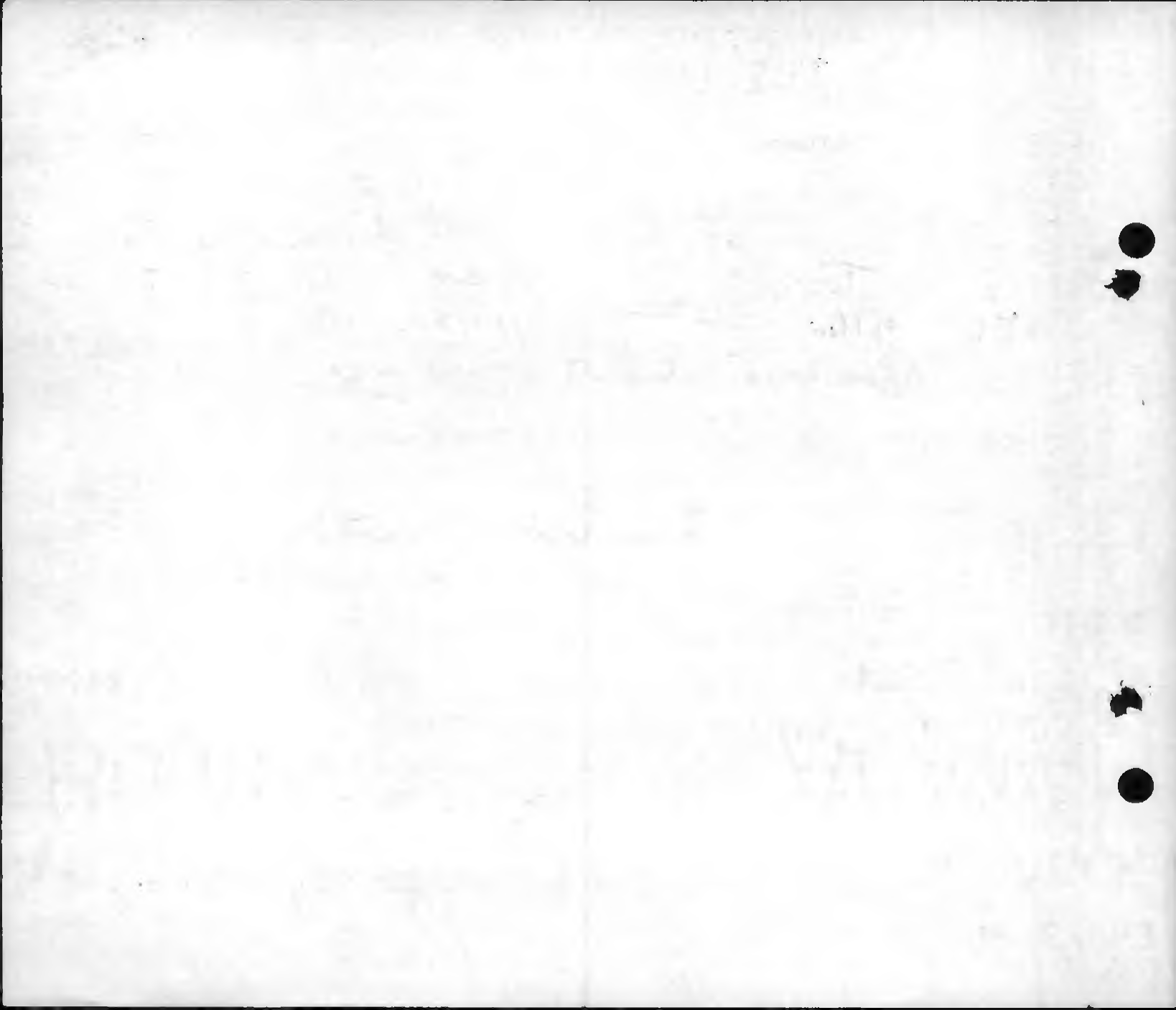
|                                            |                                                                                                   |                        |          |         |
|--------------------------------------------|---------------------------------------------------------------------------------------------------|------------------------|----------|---------|
| 21. ACCIDENT (Specify)                     | PLACE (Home, farm, factory, street, office bldg., etc.)                                           | (CITY OR TOWN)         | (COUNTY) | (STATE) |
| SUICIDE                                    | INJURY                                                                                            |                        |          |         |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | HOW DID INJURY OCCUR ? |          |         |
|                                            |                                                                                                   |                        |          |         |

22. I hereby certify that I attended the deceased from 2/27 1956, to 2/27 1956, that I last saw the deceased alive on 2/27 1956, and that death occurred at 520 PM, from the causes and on the date stated above.

|                                          |                       |                                    |
|------------------------------------------|-----------------------|------------------------------------|
| SIGNATURE                                | DATE SIGNED           | ADDRESS                            |
| Shelton B. Fess                          | 2/28/56               | Eudowood Sanatorium, Towson 4, Md. |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF          | NAME OF CEMETERY OR CREMATORY      |
| Burial                                   | Feb 28/56             | Lorraine                           |
| DATE REC'D BY LOCAL REGISTRAR            | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR               |
| Feb 28-56                                | Dec N. Duck           | Shawellaw                          |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1586  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01566  
Reg. Dist.

No. 45

|                                                                                                                |                                          |                                                          |                                                  |                                                                                     |  |                                                                             |  |
|----------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| <b>1. PLACE OF DEATH:</b>                                                                                      |                                          |                                                          |                                                  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>                                       |  |                                                                             |  |
| COUNTY <b>Baltimore</b>                                                                                        |                                          | MARYLAND                                                 |                                                  | STATE <b>Maryland</b>                                                               |  | COUNTY <b>Baltimore</b>                                                     |  |
| CITY (If outside corporate limits, write RURAL OR and give nearest town)<br><b>TOWN</b>                        |                                          | LENGTH OF STAY (In this place)                           |                                                  | CITY (If outside corporate limits write RURAL and give nearest town)<br><b>TOWN</b> |  |                                                                             |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><b>107 Kingston Road</b>                                          |                                          |                                                          |                                                  | STREET ADDRESS<br><b>107 Kingston Road</b>                                          |  | (If rural, give location)                                                   |  |
| <b>3. NAME OF DECEASED:</b> (First) <b>Debra</b> (Middle) <b>(DEBORAH)</b> (Last) <b>Zeigler</b>               |                                          |                                                          |                                                  | <b>4. DATE OF DEATH</b> (Month) <b>2</b> (Day) <b>19</b> (Year) <b>56</b>           |  |                                                                             |  |
| <b>5. SEX:</b><br><b>Female</b>                                                                                | <b>6. COLOR OR RACE:</b><br><b>White</b> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> | <b>8. DATE OF BIRTH:</b><br><b>Oct 10 - 1954</b> | <b>9. AGE last birthday:</b> yrs. <b>16</b>                                         |  | <b>IF UNDER 1 YEAR</b> Months <b>16</b> Days <b>16</b> Hours <b>16</b> Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <b>infant</b> |                                          | <b>10b. KIND OF BUSINESS OR INDUSTRY:</b>                |                                                  | <b>11. BIRTHPLACE</b> (State or foreign country):                                   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b>                                         |  |
| <b>13. FATHER'S NAME:</b><br><b>George L. Zeigler</b>                                                          |                                          |                                                          |                                                  | <b>14. MOTHER'S MAIDEN NAME:</b><br><b>Mildred Morgan</b>                           |  |                                                                             |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)   |                                          | <b>16. SOCIAL SECURITY No.:</b>                          |                                                  | <b>17. INFORMANT &amp; ADDRESS:</b><br><b>Parents above</b>                         |  |                                                                             |  |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                               |  |                                                        |  |                                                                                            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|
| <b>18. MEDICAL CERTIFICATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                               |  |                                                        |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                                                    |  |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                               |  |                                                        |  |                                                                                            |  |
| <b>Immediate cause</b> (a) <b>Suppurative Otitis Media, Left.</b><br>DUE TO<br><b>Antecedent cause(s)</b> (b)<br>Diseases or conditions, if any, giving rise to the above cause DUE TO<br>stating underlying cause last (c)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                               |  |                                                        |  |                                                                                            |  |
| <b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                               |  |                                                        |  |                                                                                            |  |
| <b>19a. DATE OF OPERATION:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>19b. MAJOR FINDING OF OPERATION:</b>                                                                       |  |                                                        |  | <b>20. AUTOPSY?</b><br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| <b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | <b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>                                 |  | <b>21c. (City or town)</b> (County)                    |  | <b>(State)</b>                                                                             |  |
| <b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> M.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b>                      |  |                                                                                            |  |
| <b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b><br>SIGNATURE <b>Paul F. Men</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2/20/56</b><br>M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> |  |                                                                                                               |  |                                                        |  |                                                                                            |  |
| <b>23. BURIAL, CREMATION, REMOVAL (Specify):</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | <b>DATE THEREOF</b>                                                                                           |  | <b>NAME OF CEMETERY OR CREMATORY</b>                   |  | <b>LOCATION (City, town, or county) (State)</b>                                            |  |
| <b>Burial</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | <b>Feb. 22 - 56</b>                                                                                           |  | <b>Cedar Hill</b>                                      |  | <b>Baltimore, Maryland H.A. Co. Md</b>                                                     |  |
| <b>DATE REC'D BY LOCAL REG.</b> <b>2/20/56</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | <b>REGISTRAR'S SIGNATURE</b><br><b>Garth Hurley</b>                                                           |  | <b>24. FUNERAL DIRECTOR</b><br><b>John D. Connolly</b> |  | <b>ADDRESS</b><br><b>Exeter</b>                                                            |  |

BUREAU V. S.

FEB 29 1956

RECEIVED